IN THE COURT OF COMMON PLEAS
TRUMBULL COUNTY, OHIO

STATE OF OHIO,	:	
Plaintiff,	:	Case No. 01-CR-794
-vs-	:	
NATHANIEL JACKSON,	:	Judge Stuard
Defendant.	:	

NATHANIEL JACKSON'S PROFFER

VOLUME II OF III

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PSYCHOLOGICAL REPORT

SUBJECT: Nathaniel Jackson DATE: 11/12/02

REASON FOR REFERRAL:

Mr. Jackson was evaluated as part of developing information relevant to the mitigation phase of his capital murder trial.

PROCEDURE:

Interviews of Mr. Jackson by S. McPherson and D. McPherson; psychological assessment administered by D. McPherson, M.Ed., assisting psychologist: Thematic Apperception Test, WAIS-3, MMPI-2, WRAT-3, and Bender Gestalt. Rorschach administered by S. McPherson. Review of records from discovery and from other sources. Contact with family members.

RESULTS

Defendant's Retrospective on His Own History:

He was asked to discuss his life in stages. When asked about his first five years, he said that his maternal grandmother was very important to him, as was his mother. He had an older brother, Charles, and a younger sister and brother, Taushia and Anthony, respectively. He did not have very much contact with his biological father (Charles Paige), remembering perhaps two times when he saw the man. He lived with his mother, and he frequently spent time with his maternal grandmother. (Other records indicated the two younger children were the product of his mother's marriage to Anthony Komegeay.)

With respect to his elementary school years, he said that he tried to do his best and in many ways he really liked school, but he also got into a lot of difficulty and tended to have problems with other students at times. He knew that he had been identified as having a behavior problem, and he stated that when he was placed in the Stambaugh School Special Program he did best. Interestingly, he remembered being taken out of that program after he had apparently done somewhat well and put back into the mainstream curriculum with the result that he immediately got into trouble again and was put back in

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Stambaugh's Special Program where, at least per his recollection, he did better once again. He left school at the age of 17 while he was still in the 11th grade.

From that time onward, his life involved basically living on the street in what was a crime-ridden and violent environment. He did have some regular jobs from time to time, but none of them were high paying. His drug use (see below) was also a part of his problem. He began getting into trouble almost immediately upon moving out from his mother's house.

He had a series of relationships, and he began getting into more and more trouble of a legal type (see below). Throughout the ensuing years, he had several relationships, one with the mother of his daughter, now age seven. That individual is now married, but he has tried to have some contacts with his daughter. He also has a son who would now be four years of age. He has had no contact with that child whose life has been a somewhat tragic story in and of itself. The child was born to Mr. Jackson and his then significant other. Shortly after birth, the child had a stroke and went into some seizures and was life-flighted to Rainbow Babies' & Children's Hospital. Over an ensuing period of time, the youngster was stabilized and diagnosed upon exit as having cerebral palsy. To the best of his knowledge, the child continues to be wheelchair bound or in a brace with limited ability. Subsequently, the relationship broke up, and the mother of the child placed the youngster with her mother, essentially abandoning him. When Mr. Jackson tried to visit his son, the maternal grandmother obtained a Restraining Order, and he has never been allowed to see him since.

Mr. Jackson indicated he grew up in an extremely violent neighborhood. (Consistently, there is the letter in the school records from his mother indicating that he should be given an excused absence because a man and a woman had been shooting at him.) After he left his mother's home, he was still primarily living on the street and in a neighborhood of significantly antisocial and violent people. He himself was shot four or five times. He indicated that for the most part, he had not obtained any hospital or medical attention for these events; in fact, he said he carried a bullet in his torso somewhere which causes him periodic difficulty. He sometimes more or less freezes and is unable to move until the spasm passes. He has been shot in the left arm, elbow, and head, all of these wounds involving grazing injuries. In addition, he indicated that he had a significant relationship with a woman and, in fact, was considering a permanent union when she was killed. She was apparently involved in some type of merchandising occupation and was killed by someone who wished not to pay for the merchandise obtained from her. Mr. Jackson also recounted that there was an occasion in which he left some clothes at the home of a person whom he viewed as a friend and with whom he had stayed briefly. When he returned to get his clothing, that individual confronted him with a gun and was not willing to give Mr. Jackson his clothes. He noted that he had a particularly nice set of outfits at the time. He felt the man's turning on him was a major wrong because he had trusted him and viewed him as a friend.

The relationship that he had with Donna was one where he thought he would avoid the problems he had had with some of the younger women with whom he engaged. He acknowledged that Donna was significantly older then he. He said that he thought perhaps it would work out better because she would be more stable and more able to provide responsibly for him. He said that she indicated to him that she was divorced in 1985 and that her ex-husband, though he now lived with her, was not romantically involved with her.

Test Results:

Results from the WAIS-3 were as follows:

Vocabulary	5	Picture Completion	8
Similarities	5	Digit Symbol-Coding	6
Arithmetic	5	Block Design	7
Digit Span	12	Matrix Reasoning	13
Information	5	Picture Arrangement	10
Comprehension	5		
Verbal IQ	82	Performance IQ	89

Full Scale IQ – 84

Above results showed significant variation among the subtests but overall performance, given test bias factors and educational deficit, reflected low average or better capacity. Deficit areas would be consistent with longstanding learning problems.

Results from the Bender-Gestalt showed no significant deficits of performance. There were some distortions and inadequacies that appear to be reflective of some lack of investment in performance.

Results from the Wide Range Achievement Test – 3 were as follows:

	Raw Score	Std. Score	%tile	Grade Score	Absolute Score
Reading	36	75	5	5	503
Spelling	43	103	58	HS	524
Arithmetic	46	111	77	HS	532

Above results reflected significant relative deficit in reading skills.

Results from the MMPI-2 indicated a need to present well and to overstate virtues. At the same time, there was a tendency toward some endorsement of symptoms that suggested an over-presentation of pathology. The overall handling of the test was inconsistent at times and interpretation, therefore, has to be somewhat guarded. What can be stated, however, is that there was neither a consistent attempt to look bad nor a consistent attempt to overstate positives. The main scale profile did not show over-statement of pathology. There was a spike 4 configuration that reflects endorsement of antisocial attitudes and/or impulsive behaviors. He showed concerns and anxiety about his current situation and the likely outcome. There were also some problems when it came to storing of angry feeling and he appeared to be an individual who can lose control because he has been storing and suppressing a lot of negative feeling without being aware of the degree to which he does so. Sub-scales reflected his sense that he is being pursued and persecuted, which is not inconsistent with his current reality situation and also that he feels a sense of alienation from his own functioning. He attempts to put on a facade of being in control and not caring what is happening but, in fact, there is an underlying significant apprehension. At the same time, he can affect a kind of cynicism which may mislead others to believe that he is in control of himself and the situation. Critical items include acknowledging misuse of alcohol and use of marijuana as well as endorsing that he has made mistakes in his life. There is some tendency toward blaming of others but it is not a pronounced assertion.

Projective tests provided some; insight into underlying personality characteristics and potentials. Analysis of thematic materials on the TAT indicated an individual who does not know how to go about managing life but who has incorporated that he should know better than he does. He has no real concept of how to proceed and there is no one available to provide him with guidance. Life tends to hand down punishment for bad behavior and he has learned to accept what happens but not to evaluate and plan to avoid negative consequences. He does not see much potential in the workplace, which is consistent with the reality of his environment. He cannot figure out how people fit into situations or what they are thinking. In effect, he is a poor reader of people even though he thinks he knows about them.

Results from the Rorschach, evaluated using the Exner protocol, indicated a valid and reliable record for interpretation. There were no indications of any serious mental health pathology, but rather he appears to be an individual who lacks the capacity to cope adequately with his environment. He tries to keep emotions at bay but doesn't have the wherewithal to do so and still adequately manage other and often pressing demands. He is rather constricted and limited in how he responds to others. The avoidance of processing emotional stimulation is extreme and suggests a defense in order to avoid feeling the painful affect that comes about when he lets himself be vulnerable to contacts by others. This feature is consistent with the history of behavioral deficit and lack of environmental support and effective intervention. There are underlying negative to self attitudes which he also tries to avoid directly experiencing. At the same time, there is self focus, a pattern associated with insecurity and neediness. He is significantly limited when it comes to dealing relationally as might be expected, and again his history has

involved difficulties that he has sought to remediate but has not the least idea as to how to handle. He tends to be guarded in how he approaches situations but the defensive stance means that he is not aware of all the aspects of the world that he needs to be in order to manage. He makes decisions on inadequate information and thus adds impulsivity of thinking to the existing disinhibitions that are part of the hyperactivity complex.

Legal History

His initial problems with the legal system occurred in his mid-teens when he did about six months in detention home. He had been charged in connection with driving violations and unruly behavior. He apparently was absenting himself from school. After he became an adult he worked at various jobs but did not have any regular or ongoing employment of any substance. He was incarcerated four times at Lorain Correctional as follows: 1/92 for aggravated burglary; 2/96 for having a weapon under disability (as a convicted felon he is not allowed to have a gun); 2/01 for charges in connection with a stole vehicle and stolen license plates. He apparently was briefly released but did not follow up appropriately while on parole and was returned to the facility and then released on 12/12, after which the crime took place. He was also arrested in connection with receiving stolen property, unauthorized use of a vehicle, and driving under suspension. According to the defendant and his counsel, during his time in prison he did not present as an adjustment problem.

School Records:

He did not complete the 11th grade and there was inconsistent attendance and involvement before he finally dropped out. He attended a number of different schools. School records indicated the following.

Behavioral problems were noted as of the 1st grade, or immediately upon his entry into a formal academic setting. Those behavior problems continued throughout the time that he was in school up through the 11th grade level, which was the point at which he left. By the 3rd grade, he had been suspended. He was finally assessed at the 4th grade level and found to have significant problems and to be in need of special educational assistance. At that time, His Wechsler Intelligence Scale results were: Verbal IQ, 72; Performance, IQ, 78; and, Full Scale IQ, 73. Interestingly, while he had below grade level achievement, he was not deficient at the level that the above score, particularly the Verbal one, might have suggested, particularly given that he was coming out of an environment that was not conducive to correcting or assisting him with his problems. However, consistent with the 4th grade results, in 1989 at the 10th grade level, he was tested with the Stanford-Binet and obtained an IQ of 70.

Other information from the school records indicated a pattern of absenteeism which tended to increase over the course of the year, a high potential for getting involved in altercations with peers, behavior problems on the bus and it was also noted as of the 9th grade that he was at high risk for chemical dependency.

Axis IV – Problems with primary support group, Problems related to social environment, Educational problems, Legal Problems.

Axis V – GAF = 40; major impairment in several areas of function

Summary:

Mr. Jackson is an individual who was raised in an environment that was significantly violent and dyscontrolled that persons surviving in the situation would have been more likely than not to develop a sense of chronic threat and insecurity. Consistently, his own story is one where he has had to defend himself and where fights have not been infrequent, with fairly serious consequences to those participating. Early educational difficulties and current test results are consistent with the presence of an AD/HD component. The history of significant drug abuse starting at the age of 13 and probable dependency on marijuana is also a pattern that is well known for AD/HD persons. There is vulnerability to use, abuse and dependency on drugs to alleviate the chronic tensions and to escape the punishment that comes from the environment as a result of behavioral dyscontrol. Consistently, he chose not to abuse drugs such as methamphetamines or PCP. His use also reflected an occupational component in that he was living in a drug infested environment and, at least sometimes, involved in the lifestyle of using and selling. Given his educational limitations and social situation, obtaining employment with reasonable compensation in the depressed area in which he lived was unlikely.

His mother was on her own much of the time. Although he loves her and his grandmother, they were unable to intervene effectively with his special behavioral and learning needs. As time went on, the family system fragmented further. At the present time, his mother indicates she does not know the status of his sister and cannot be sure how to reach her. Similarly, she was unsure of the current situation of either of his brothers. She stated she works at a physically demanding job and has little energy except to go home and rest so as to be able to work the next day.

He had no male figure immediately available to him to provide him with alternative guidance from what was occurring as a function of his finding his own way in a hostile situation. There was thus no real functioning family system for him as he tried to deal with his needs for support. He does have the capacity to relate to other human beings, and it has been indicated in the records obtained that he has some artistic potentials.

His vulnerability to influence within the context of the relationship to Donna was high: she was older, apparently stable to his view, held out a promise of a more financially secure existence, and catered to his need to be seen as adequate.

He has been able to maintain himself in a stable fashion when he was prior incarcerated and, therefore, it can be reasonably inferred that he can be a productive member of the general population.

Sandra B. McPherson, Ph.D. ABPP
Clinical and Forensic Psychologist

IN THE UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF OHIO

WESTERN DIVISION

DAYTON

- - -

LAWRENCE LANDRUM, :

Plaintiff, :

Vs. : Case No. C-196-641

BETTY MITCHELL, : Thursday, 9:00 a.m.

Defendant. : September 4, 2003

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EVIDENTIARY HEARING BEFORE

JUDGE MICHAEL R. MERZ

- - -

APPEARANCES:

FOR THE PLAINTIFF:

Gerald W. Simmons, Esq.

Randall L. Porter, Esq.

FOR THE DEFENDANT:

Jonathan R. Fulkerson, Esq.

Michael L. Collyer, Esq.

COURT REPORTER:

Shandy Ehde, RPR

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person who did this terrible, terrible thing, you know.

Q. You indicated that at the time you did your work before the post-conviction process, that some of the records that you might have wanted to see had been destroyed or were missing. And I note that you were initially involved in the case in '91, you were asked to do the social history in '93, you completed the social history in '96. Do you have any idea why there was such a long delay between trial and post-conviction?

A. No. I mean every state is different in terms of how it moves cases.

THE COURT: You may step down.

THE WITNESS: Thank you.

(Witness was excused.)

THE COURT: Mr. Simmons, you may call your next witness.

MR. SIMMONS: Yes, your Honor. Dr. Smith.

ROBERT L. SMITH, Ph.D

witness herein, being first duly sworn, testified as follows:

DIRECT EXAMINATION

MR. SIMMONS: I think counsel has -- she's going to stay a while to hear the doctor's testimony.

THE COURT: Once she's testified, she has a right to be here.

BY MR. SIMMONS:

Q. Would you please tell the Court your name and address?

A. Robert Lee Smith, Ph.D. My address is [redacted] West Lake, Ohio.

Q. Would you please tell the Court what your practice entails?

A. Yes. I'm a clinical psychologist and a certified addiction specialist.

Q. What is the nature of the certification? Where does that come from?

A. The license in psychology is from the State of Ohio. Basically it comes as a result from having my doctorate from an APA approved from an academic program, and then I did an internship and post-doctorate internship in psychology and addiction. The certification addiction specialist is a national certification and is awarded once you're able to demonstrate appropriate educational and clinical experience.

Q. Have you had occasion to testify as an expert witness previously?

A. Yes, I have.

Q. Could you please tell the Court in general terms the quantity and nature of the testimony in which you've engaged?
A. I've probably testified in about 25 to 30 cases nationwide. Most of those have been either death penalty cases or appeals, but I've also worked in some civil litigation as well.
Q. And what is the nature of the testimony that you have generally given?
A. Generally what I've been asked to do is to conduct an evaluation of the defendant and determine whether or not there are any valid psychological diagnoses or disorders that could be presented to the court for mitigation.
Q. Could you please look at Exhibit 7?
A. (Witness complied.)
Q. What is Exhibit 7, please?
A. It's my curriculum vitae.
Q. Is it accurate and complete?
A. As far as I can tell it looks accurate, yes.
Q. Okay. Now there's a reference here to Behavior Management Associates, Inc, What is that?
A. It's a private practice group in which I'm one of the associates. I basically rent space from them and conduct a private practice in a suburb of Cleveland

with Behavior Management Associates.

Q. What is the nature of your private practice?

A. It's a clinical practice. I work with adults and adolescents. Basically a full range of psychological disorders as well as addictive disorders.

Q. What types of people do you deal with in your practice?

A. In my private practice, generally they will be men and women who have marital problems, occasionally will be individuals with depression and anxiety disorders. Most of the clients that have addictive disorders come because they are having difficulties maintaining abstinence. Most of them have a history of physical or sexual abuse that has not been adequately addressed so that interferes with their recovery.

Q. Do you do any clinical work in addition to your private practice?

A. Yes, I do.

Q. And tell the Court, please, what that involves.

A. I work as a director of operations for an organization called Stella Maris. Stella Maris is an alcohol and drug treatment facility in Cleveland. They have a 16-bed detoxification unit in a 42-bed therapeutic community. I began working with that

organization about four years ago.

Currently I'm a project director on a national federal grant. The goal of the grant is to conduct a research project. We're examining the treatment of homeless, chemically dependent and mentally ill male offenders. These men are referred through the court system in Cleveland. They're all homeless. They have a long-standing history of addiction, and about 60 percent of them have a co-curring mental illness. The treatment model that we have put together is, as a demonstration project, we're about a year and a half through the project. Our goal is to gather information about the effectiveness of the treatment and to hopefully come up with ideas and approaches that are more effective.

Q. Have you applied for, and have you received, any government grants in this area?

A. I have the current grant, and I also had a grant in 1993 with the Federal Government. Again the goal was to look at the treatment of homeless, chemically dependent women. The women who came into treatment were either pregnant or who had custody of one or two children. We developed a treatment design that allowed the women to come into treatment and bring their children with them. Again about 40 percent of

the women had a co-curring mental illness, and approximately 80 percent of them had a history of being physically and sexually abused.

Q. Have you done any work with the hospitals in the Cleveland area?

A. Yes, I have.

Q. And would you please tell the Court what that has involved?

A. Currently there's two primary hospitals that I have ongoing work with. I work with University Hospitals of Cleveland. I conduct a residency assistance program. If an intern or a medical resident has some type of personal problem, depression, anxiety, perhaps abuse of alcohol or drugs, marital difficulties, the university -- I mean the hospital will contact me. I'll do an assessment of the intern or resident, and then either do short-term therapy or link them to appropriate services.

I also work with Metro Health Medical Center, which used to be Cleveland Metropolitan General Hospital. I helped develop the employee assistance program when I worked there many years ago, and so what has happened is they have continued to keep me as a consultant even though I'm in private practice. So

I work with them on a weekly basis, looking at more difficult cases and helping the counselors sort of manage those cases.

Q. Have you done any lecturing in this field?

A. Yes, I have.

Q. And could you again tell the Court, please, what you have done in that regard?

A. The bulk of the research -- I mean the lecturing has been related to my research and clinical experience, and it's at Case Western Reserve University. I currently have an academic appointment with the department of psychology, and last year taught a course on mental illness and substance abuse, but I also have taught for the medical school and for the law school at Case.

Q. Have you done any continuing legal education for attorneys?

A. Yes, I have.

Q. And would you tell the Court, have you written any articles of any significance in this area that you think are pertinent to your experience?

A. I have several articles that we've published. Most of them have focused on identification and diagnosis of addiction, but we also have taken a look at the treatment of minorities and special

populations, and that's really where my research area is now.

Q. I take it that you have had an opportunity to review the work of Miss Miller, that is, the post-conviction work, the affidavit and the report that she did?

A. Yes, I did.

Q. And I take it you've also had a chance to review the court records of Mr. Landrum's trial, initial trial?

A. That's correct.

Q. Would you please look at Exhibit 4 and -- I'm sorry. John?

MR. FULKERSON: Before we proceed into the specifics on Mr. Landrum's case, I would like to clarify a few points on the witness' qualifications if this is the proper time to do that.

THE COURT: The voir dire may be allowed.

MR. FULKERSON: Thank you.

VOIR DIRE EXAMINATION

BY MR. FULKERSON:

Q. May it please the Court, counsel.

Dr. Smith, I'm Jonathan Fulkerson. We met briefly before we started. I want to ask you a couple questions about some of your qualifications before we

proceed this morning.

Do you have a board certification in psychology?

A. No, I do not.

Q. Are you a member of the, or do you know what the ABPP is; American Board of Professional Psychology?

A. Yes, I am aware of that.

Q. Are you a member of that organization?

A. No, I am not.

Q. You said on your initial testimony that you have a national certification as an addiction specialist?

A. That's correct.

Q. Where is that from?

A. I'm sorry, where is --

Q. Who gave you that certification; what organization?

A. The American Academy of Healthcare Providers and Addictive Disorders.

Q. Okay. And when did you obtain that certification? What year, do you remember?

A. No, I don't know offhand.

Q. Was it before 1996?

A. Yes.

Q. Okay. That organization's certification, you didn't have to take an exam to get that certification, did you?

A. No, I did not.
Q. And you were allowed to join without taking a national examination in order to get that certification; correct?
A. That's correct.
Q. Okay. You said that you do a lot of work as an associate with Behavior Management Associates?
A. I have a small private practice with them.
Q. Small practice. You do a lot of work with adults and adolescents that have addictive disorders; is that what you said? Am I correct?
A. Again based on Behavior Management Associates.
Q. I'm sorry, just talking about behavior management.
A. That's correct.
Q. You don't really deal with criminal assessments with Behavior Management Associates, do you?
A. Occasionally I will have a forensic evaluation through the organization, but that's a small part of my caseload there.
Q. But essentially Behavior Management Associates is kind of an employee assistance program; isn't that correct?
A. No, that's not correct.
Q. I want to have you refer to volume I of the

binder that I have provided to the Court and you, and I'd like to have you look at page 1 of that. And for your reference and the Court's, I've caused the bottom right corner of all these pages to be Bates stamped for convenience.

If I can ask you just to look at page 1, can you identify what that page and the preceding few pages are behind that?

A. Yes.

Q. What is that?

A. That's the employee assistance program that is the subset of what Behavior Management Associates does.

Q. And doesn't that say there that, "Behavior Management Associates provides complete program that addresses employee problems that include comprehensive work/life services and can be enhanced with ancillary service"?

A. That's correct.

Q. But it's not an employee service program?

A. You misunderstood my response. I said Behavior Management Associates is not an employee assistance program. This employee assistance program is called Impact, that's the employee assistance program. I have nothing to do with it.

Q. Thank you. Your CV also says you are a member of the College of Examiners?
A. That's correct.
Q. Are you a life member or yearly member of that organization?
A. I'm not sure of the distinction.
Q. Well, doesn't that organization -- there are two ways you can join. You can either join every year and pay every year or you can pay a larger fee and be a member for life?
A. I'm an annual member.
Q. Your are an annual member?
A. That's correct.
Q. Isn't it true to become a member of the organization you essentially self-certify yourself and agree to abide by their code of ethics to become a member?
A. That is part of it, correct.
Q. Is there an additional part of that that is required?
A. Yes. They now have testing. They also have continuing education requirements --
Q. Could you explain?
A. -- that are part of becoming certified.
Q. Okay.

MR. FULKERSON: That's all I have about his qualifications your Honor. Thank you.

THE COURT: You may resume your examination, Mr. Simmons.

FURTHER DIRECT EXAMINATION

BY MR. SIMMONS:

Q. Thank you, your Honor.

Dr. Smith, I'd like to ask you to please look at Exhibit 4 in the exhibit book.

A. (Witness complied.)

MR. SIMMONS: Just to keep things confusing, your Honor, it actually has an Exhibit 5 in the lower right-hand corner.

THE COURT: I'm going to mark that out on my copy.

THE CLERK: I'm restickering.

THE COURT: Thank you.

Q. Dr. Smith, have you, based upon your review of the records in the initial trial and your review of Miss Miller's work, and the other investigation you've done, formed some opinions about Mr. Landrum's psychological state at the time of the murder and also at the time of his trial?

A. That's correct.

Q. Could you please in a general way state to the

Court what you have, what these opinions are, and then we'll get into some specifics.

A. Sure. Basically I believe that at the time of the offense Mr. Landrum was dependent upon several chemicals. Alcohol, sedatives and cannabis, or marihuana. I also believe at the time of the offense that he was under the influence of alcohol and sedatives, that he was suffering from a psychological disorder that had been long standing from adolescence.

This depressive disorder is called dysthymia or disthymic disorder, and he as a child suffered a number of significant traumas and abuse that led to his development of depression and later his addiction to alcohol and other drugs.

THE COURT: Before we proceed, would you be gracious enough to spell dysthymia for the record?

THE WITNESS: D-y-s-t-h-y-m-i-a.

THE COURT: Thank you.

Q. And did this disorder that you have described have an impact on his cognitive abilities during this period of time?

A. Absolutely.

Q. And what was that?

A. In order to understand Mr. Landrum's function, you would have to take a look at all the disorders in

combination.

Disthymic disorder in and of itself has a number of influences upon both how a person feels, how they think and how they act. When a person has this type of chronic depression they often feel hopeless, helpless. There's a sense of agitation in their ability, low self-esteem, feeling they can't be successful, they can't do anything right. There's an underlying despair which leads to them to engaging in self-defeating behaviors.

Oftentimes they will attempt to do things, but because they believe they'll fail, they do. And so people with dysthymia have failed relationships, oftentimes are unable to maintain employment, and will turn to alcohol and drugs as a way of coping with this ongoing depression.

The use of alcohol and drugs of course changes the way the brain works. Alcohol is a central nervous system depressant. It slows down the brain, it results in impulsist mood swings, agitation, irritability, sometimes aggressive behavior. Mixing that with another drug, which Mr. Landrum did frequently, such as Ativan which is a sedative, in fact Ativan directly enhances the effects of alcohol so that it's not just an additive factor but

multi-flexitive factor, so that an individual taking alcohol and Ativan together will be significantly impaired in terms of their ability to focus, concentrate, interpret events that are going on around them.

Their motor movements may be, but it depends. People using with high tolerances, abusing substances for a long time, their body develops an ability to adapt to the effects of the chemicals, so they may be able to walk a straight line, they may be able to speak without slurring their words too badly. But in fact what's happening is their cognitive functioning is significantly impaired, just it's masked by their ability to walk and talk.

Putting the depression together with the effects of alcohol and the sedative, the individual's ability to comprehend a situation, concentrate, focus, consider their options, weigh the pros and cons, consider the consequences of their actions would all be significantly impaired.

Q. Was there any effort in the mitigation phase of this case to explain, for example, the relationships that you've just discussed between various drugs and alcohol?

A. I did not see any attempt to make that connection

explanation.
Q. Was there any discussion of any relationship between Mr. Landrum's depression or this disorder that you've described and his use of these substances?
A. Not that I'm aware of.
Q. In working with -- in coming to your conclusions, could you tell the Court what events or what history of Mr. Landrum, what events in his life to you were significant in coming to your opinions, and in particular if, while you're doing it, you could mention which of those, if any, were not dealt with in the original trial?
A. Yes.
Q. Just sort of go through his life, the significance of the various events and explain whether they were or were not dealt with in your view properly or at all at the original trial.
A. Okay. As a beginning statement, I think I would say that most of what I'm going to say I do not feel was adequately developed and discussed in the original trial.

What I'm looking at when I look at Mr. Landrum's background is a developmental history. I'm looking at how do these events impact the development of the child, how does that child cope with those events,

what is their response, what choices do they have available to them, what disorders may they develop, how do those developed disorders then affect ongoing sort of maturation and life choices, and then how, ultimately, did all of those things impact Mr. Landrum's behavior at the time of the offense.

I don't believe that the initial trial did much of that at all. I can kind of walk through these.

First things to become important are the absence of a father. For the first four years Mr. Landrum has no father figure that's present. His mother is somewhat present, but because of her schooling and work and because of the home environment, her involvement with Mr. Landrum was also limited.

THE COURT: What about the maternal grandfather?

THE WITNESS: We do have a maternal grandfather. Now he becomes very significant because he uses alcohol, and it's not every day but it is regular and it's excessive, and when he drinks to excess, he's abusive. Now that becomes important because Larry's going to be forming some opinions about the use of alcohol and what is appropriate behavior when you drink. His grandfather uses

regularly, becomes out of control, becomes violent. That becomes a socially acceptable behavior in some ways.

A. Then we have maternal aunts and uncles who also abuse alcohol and drugs. Now there's a couple ways to look at it, and I'm going to kind of talk about the development for Larry in several areas. If we want to look at his development of addiction, there are three things that put a child at risk for addiction. Genetic factors, environmental factors and psychological factors.

In Larry's family, we have genetic factors, we have a maternal grandfather who abuses alcohol and drugs, and we have maternal aunts and uncles, so we know there's a family history of substance abuse.

THE COURT: We don't know. Of course we know there's a family history. We don't have any determined, clinically determined patterns of tracing that genetic occurrence, do we have, in the matter of available science?

THE WITNESS: What the literature has shown us, if you have immediate family members, defined as parents, grandparents, aunts and uncles, if you have a significant history of substance abuse, the children are predisposed. It's not a direct genetic

inheritance but a predisposition, sort of like with cancer, so that children who come from a family history where there's cancer, we know that they're at risk. That's what we really know about the children.

The literature is suggesting that it's five times greater risk than for children who do not have a significant family history. But that's only one of the factors.

A. The second factor becomes environment. Children who grow up in a home where alcohol and drugs are readily available and where the parental figures or adult figures use alcohol and drugs are more likely to experiment and use drugs than their peers. What we have is, we have a grandfather, we have the aunts and uncles, later we have the stepfather, all who use alcohol and/or drugs on a regular basis, and that's part of family life. So that is another factor that contributes to it being okay to Larry to begin experimenting with alcohol and drugs.

The final factor is that we know that children who suffer physical abuse or sexual abuse are much more likely to begin using alcohol and drugs as adolescents. When we look at Larry's background, we have sexual abuse at the age of five. We have physical abuse by the stepfather over a number of

years. And we have numerous losses, the death of his grandmother, that he now is trying to cope with.

As a result, what we have is all three factors contributing to Larry's use of alcohol and drugs. It wasn't just one factor, but all three.

The other thing you begin to look at is, well, what makes something traumatic for a child? Why should these events have an impact on Larry? We've got dad out of the picture, we've got mom who is preoccupied, and then we've got the death of grandmother. We've got physical and sexual abuse. We've got the stepfather. Why should all those be significant?

Well, what we know from the research now is there are a number of things you can look at. One is to what extent is the event something that normally occurs in childhood. If it's a normal event, the child should be able to talk to friends, family and others, and work it through. It's not something that's strange or odd or something they should be embarrassed or ashamed about. The problem is that a number of things that happened in Larry's background were not normal events. Being sexually abused at the age of four and five is not a normal event for a child.

THE COURT: How abnormal is it, ideologically speaking, do you know?

THE WITNESS: In terms of percentages we're probably looking at less than three percent of the population overall experiences sexual abuse at the age of four or five. We do know that for females, adolescence is a more likely period for sexual abuse to occur.

A. The other thing that becomes significant is the age and the mental status of the victim when the trauma occurs. The less capable they are to process what happened to them, to talk about it, verbalize it and work it through, the more they're going to be traumatized by the event. So the age becomes significant, the level of maturity, the intellectual functioning are all factors.

Many of these events that occurred in Larry's life, he was very young, did not have the mental capability and the maturity to be able to work it through.

The next thing becomes how many traumas you have occur in your life. A single trauma can leave a lasting scar throughout a person's life, but multiple trauma becomes significant, because trauma basically tells me the world is a dangerous place and I have to

be very cautious, in fact maybe I need to even be aggressive to keep myself safe. If I have repeated trauma, that just keeps reinforcing to me that the world is dangerous and that life is filled with all sorts of hurt and pain and loss.

The last thing has to do with the recovery environment when a child has gone through repeated trauma. How supportive, how nurturing, how aware of the trauma are the family members, the parents with the child? Do they talk about it, do they work it through, do they get the child counseling and assistance for those disorders?

When we look at Larry's childhood there just wasn't the type of recovery environment to help him work through the traumas that he went through which again then contributes to his turning to alcohol and drugs as a way to sort of medicate himself and deal with his emotional pain.

Q. You have discussed the family situation as a young child, and I just wanted to be sure that you had, you feel you fully explored that. Have you discussed the situation in Sault Ste. Marie until he moved to the fullest you think appropriate?

A. Well, I think the other part that I would want to add is dysthymia is a chronic underlying depression

that oftentimes begins in the early adolescence and can persistent for many years. It is somewhat biologically based, but what we have been able to discover is that ongoing trauma tends to be one of the contributing factors to a person developing this kind of depression. That sense of helplessness and hopelessness, the inability to correct my situation, make my life better, that I continually seem to fail, no matter what I do I can't seem to make my life right becomes an underlying theme, and so that then builds into a depressive state that persists into adulthood.

Q. Is there any significance to your view in the remarriage of Mr. Landrum's mother and the move to Chillicothe in this analysis?

THE COURT: I think technically we're not talking about a remarriage. I think we're talking about a first marriage.

MR. SIMMONS: I think we are. Excuse me. Marriage.

A. The marriage becomes significant in several ways. First, mother moves and lives with in-laws, which allows Larry to be alone without his mother for about a month, which when you're looking at the age that he's at, is pretty traumatic. Even though the mother was not necessarily the best mother and always

present, she was there. Now she's completely absent.

Then after about a four- to six-week period, the mother removes Larry from his family completely, moves to another city, and now he's not able to see his grandparents, aunts, uncles, cousins. He's completely removed from them. And then lastly he's now adapting to this parental figure who is rather stern, has bouts of rage and abuses alcohol, and then at a later point discovers that this in fact is not his father but is his stepfather.

So there were a number of events that occurred in that transition that contributed to Larry's feelings again of loss, depression and attitudes about the use of alcohol.

Q. Is there any significance to Larry's experiences in his teenage years at either Upham Hall, the Fairfield School or elsewhere that you think fit into this analysis?

A. Yes. I think the records, particularly at Upham Hall, provided significant data regarding Larry's function at age 16. At that point he had overdosed on drugs, which clearly tells us at that point that his use of alcohol and drugs had already progressed to a point where it was causing significant problems in his life.

The records repeatedly document his feeling sad and presenting with symptoms of depression, and the problems with the stepfather's violent temper, and that that needed to be addressed and needed to be treated.

Unfortunately, it was not treated. The stepfather opted to not get counseling or therapy for himself. Larry did not want to go home. He had asked to go live with relatives in Michigan. The family, the mother and father, stepfather, decided not to allow that, that Larry needed to come back home.

Things did not go well when he went back home. He was violated for his probation, went to Fairfield School, and again removed from the family. He did fairly well. His grades improved in school, his behavior was appropriate.

What we find is that his behavior deteriorated from the point that his grandmother died, his mother married his stepfather, and the physical abuse began. You can see this progression. Progression in terms of alcohol and drug use, progression in terms of depression, progression in terms of behavior that becomes more and more erratic and out of control and unpredictable.

THE COURT: Meaning his behavior, not his

stepfather's?

THE WITNESS: No. Meaning Larry's behavior. The overdose when he's in the military. His behavior becomes out of control. At times he's AWOL for days at a time. He's not able to maintain his life in an orderly fashion because of the depression and the effects of the alcohol and drugs.

Q. Did you perform any tests or ask Mr. Landrum to undergo any testing in terms of your analysis of his situation?

A. Yes, I did.

Q. And could you please explain to the Court what testing you did and what, if any, significance it has on your overall opinion?

A. I basically did four things. I conducted the Michigan Alcoholism Screening Test. This is a screening instrument to look at an individual's use of alcohol. A score of 5 suggests the person has a problem with alcohol. Larry's score was 35.

I also administered the Drug Abuse Screening Test. This is used to screen for drugs other than alcohol. Again the cutoff score is 5 to indicate a problem, and Larry's score was 23.

These screening tools just simply reinforced what the records had shown and what my interview had

demonstrated, that Larry's use of alcohol and drugs was clearly a problem and was at a level to support a diagnosis of dependence.

Also I administered the Wechsler Adult Intelligence Scale to screen for intellectual functioning, found that Larry functions in the average range overall, or full scale IQ was 105. Then I also conducted the Minnesota Multiphasic Personality Inventory.

THE COURT: I or II?

THE WITNESS: II.

A. Basically it demonstrated that his clinical scales were all within normal limits. There were no significant elevations. The only sub-scale that was significantly elevated was the scale that's used to identify individuals who have a high susceptibility to abusing alcohol and drugs.

Q. Now you know there was some testimony at the trial, I think even in the mitigation phase --

THE COURT: I'm sorry, when were these tests administered?

THE WITNESS: The MAST and DAST were July 30th, 1993, and the WAIS and the MMPI were December 10th, 1993.

THE COURT: Thank you.

Q. Doctor, as you know, there were some references in the trial, and as I say, even in the mitigation phase that Larry drank too much. In your view is what you're saying just a repeating that kind of statement or is what you're saying something significantly different?

A. I think it's significantly different in that, yes, that is one of the symptoms that Larry had was that he drank too much. But more importantly, I think it's imperative that we understand that he had an underlying depression, that his use of alcohol and other drugs, not just alcohol, was a self-medicating approach to treating his depression and dealing with a number of early life traumas and ongoing losses throughout adolescence and into adulthood, he had a number of losses as an adult, and his way of coping was to use alcohol and drugs.

So that understanding that, I think we have a better understanding of why the alcohol was there and how the addiction developed, because once an addiction develops, then the individual, yes, they drink because of other factors, but they're also now drinking because they're addicted to the substance.

MR. SIMMONS: That's all I have, your Honor.

THE COURT: Thank you. Cross.

Let me ask, I suppose, Mr. Fulkerson, it being 10 minutes of 12:00, whether you anticipate a brief or extended cross-examination such that it would be appropriate to take the lunch break now?

MR. FULKERSON: I would think not more than 30 minutes at the most.

THE COURT: All right. We'll go ahead then.

MR. FULKERSON: Okay.

CROSS-EXAMINATION

BY MR. FULKERSON:

Q. Dr. Smith, when did you first become involved with this case?

A. I don't know the exact date. It was in the early part of 1994.

Q. And you became involved in the case through the Ohio Public Defender's Office?

A. That's correct.

Q. And were you paid for your services at that time to prepare the affidavit that is in the record in this case now?

A. For this affidavit? Yes.

Q. Correct. And how much were you paid for your services for the entire post-conviction process that you were involved in in this case?

A. I have no idea. I know what I charge per hour but I don't recall the total amount.
Q. What do you charge per hour?
A. A hundred seventy-five dollars per hour.
Q. Do you have any reasonable estimate of how many hours you put in to prepare the affidavit in your investigation for post-conviction?
A. Not at this point I don't.
Q. Okay. And you're also being paid for your services today?
A. That's correct.
Q. And you're charging $175 an hour?
A. No, it's $225 an hour for court time and testimony.
Q. It's been almost 10 years since your previous investigation. How were you contacted to testify in this proceeding?
A. Again I was contacted by the Ohio Public Defender's Office.
Q. That's fine. Do you support the death penalty?
A. Yes.
Q. Your CV says that you do some work with the Catholic Charity Services of Cuyahoga County?
A. I have in the past.
Q. Are you a practicing Catholic?

A. Yes, I am.
Q. And you have no opposition to the death penalty based on your religious beliefs?
A. No, I do not.
Q. Okay. Would you agree that it's not the role of your role in mitigation to make decisions about what strategies the trial counsel should employ?
A. I'm sorry, can you say that again?
Q. You testified on direct that your role is to present a valid diagnosis of somebody at the time of the crime and provide that to the defense?
A. That's correct.
Q. You would agree with me then that it's not your role to develop trial strategies, it's for a lawyer to do; correct?
A. That's correct.
Q. And you're not a lawyer?
A. No, I'm not.
Q. Would you agree then as a general matter that it's up to counsel to make the decision about what evidence to present in mitigation?
A. Yes. I just have one qualifier. Certainly when I'm asked by attorneys to do an evaluation, I will tell them records that I would like to review, individuals that I would like to interview, if I need

more time with the defendant, so that I want to give them a thorough evaluation so I will ask for those things. It would be their determination whether or not I receive them, but I will let them know what I need or what I at least feel I need to have a full and comprehensive assessment.

Q. Okay. In other words then is it important for you testifying in mitigation that you are presenting testimony that is consistent with the defense theory of the case?

A. That's their determination whether or not what I have is consistent with their theory, but what is important to me is that I have as much information as possible to feel confident that the opinions that I'm giving are valid.

Q. Do you know the defense strategy Mr. Landrum's attorneys used at trial, at the guilt phase of the trial?

A. Their strategy? I'm not sure.

Q. Do you know what their strategy was in the mitigation phase of Mr. Landrum's trial?

A. No, I'm not sure.

Q. You don't know then whether counsel's strategy was to admit Mr. Landrum's guilt or blame someone else for the crime or show that Mr. Landrum was remorseful?

A. No, I didn't work with the attorneys so I don't know their strategies.

Q. Of the people that you work with through Stella Maris and Behavior Management Associates and your work with Case Western, those are people that generally are seeking your help; is that a fair statement?

A. No.

Q. That's not a fair statement?

A. No.

Q. People are -- just come to you? How do they get to you for assistance?

A. I have several different groups that I work with. The Hitchcock Center for Women, probably 80 percent of those are coming on their own. Twenty percent are court-ordered treatment.

Q. So it's fair to say that some are coming to you really not of their own will, but because of the court direction?

A. Right. And then the men's program at Stella Maris is one hundred percent offenders, so they have a choice, the choice is to either go to prison or go to treatment. It's not exactly the same as choosing the treatment.

Q. I understand. Would you agree then that somebody in that situation might have a motive to fabricate

information to you as a clinician because they're under judicial pressure to do so? I don't mean judicial pressure but --

THE COURT: It is judicial pressure. That's right.

Q. Well, so would you agree with me that someone in that situation has a different motivation than someone who comes to you of their own free will seeking your help?

A. It can. It can be different.

Q. And when someone's not forthcoming with you about their background and personal information for whatever reason, that's corrupting your opinion; is that true?

A. It limits your opinion. It may not -- there may be sufficient additional sources or whatever that you can still draw a valid opinion, but it would be helpful if they're forthcoming and give you the information themselves.

Q. But when they're not giving you good data, your opinion is compromised as a result; is that correct?

A. Well, no. That's why I said no. I think again it depends on the number of other sources you have. If I have school records and medical records and psychiatric records and mother and father telling me something and the defendant doesn't necessarily

disclose that, that doesn't necessarily corrupt my opinion. What it means is I know what the defendant is telling me but I've got 12 other sources that say it's true.

Q. Do you remember testifying in the Mark Brown capital case?

A. No. Not necessarily, no.

Q. If I refer you to volume II of the book that I've provided, page 126 of that book, and again the page numbers are on the bottom right-hand corner of that.

A. (Witness complied.)

Q. I'll represent to you that that page is from your testimony in the Mark Brown capital case, and if I can refer you down to lines 17 through 20, could you just read that very briefly? Page 126, lines 17 through 20?

A. Yes.

Q. You were asked a question about whether someone is forthcoming with you or not corrupts your opinion and you answered correct?

A. That's true.

Q. Okay. I just wanted to clarify that.

Now you were talking a little bit about testing and interviews. Would you say as a general matter that it's important for you to personally interview

someone in a situation like Mr. Landrum before giving your opinion for mitigation purposes?

A. I think it depends upon the circumstances of the request by the attorneys so that I don't know that I can say yes or no to that. It's a very broad statement.

Q. Do you have to interview somebody to provide the opinions that you're providing?

A. It depends on what the circumstances are and what opinion they're asking for.

Q. If they're asking you to provide an opinion about someone's psychological diagnosis, do you have to interview them or is that just not necessary if you're given, let's say school records, medical records, test records, that kind of thing?

A. I think again it's an awkward question. If I was shown that the defendant had been given an IQ test four or five different times and all of the IQ's were the same, I would probably say there's not much reason to do a full assessment again. Why? We have a steady IQ, there's been no head trauma, the individual's verbal presents normal, I wouldn't see that. If we're trying to diagnose a very significant psychological disorder that may have been only developed recently, it would be important to be able to see them because

records may not necessarily reflect that.

Q. But you interviewed Mr. Landrum twice?

A. That's correct.

Q. At least in this case it was important for you to interview him?

A. Correct.

Q. And you also reviewed some of his school records?

A. That's correct.

Q. Would you say that's important to review in preparing your opinion?

A. Again I think that it's useful.

Q. Okay. Just to recap, you did do diagnostic interviews of Mr. Landrum; correct?

A. Yes.

Q. You gave him four tests which you've described, MMPI-II, the WAIS, you gave him the Michigan Alcoholism Screening Instrument and then the --

A. Drug Abuse Screening Test.

Q. Drug Abuse Screening Instrument. Did you do any other independent investigation on Mr. Landrum's case other than the tests you did and what was given to you in order to prepare your affidavit?

A. Review of records. (Witness nodded.)

Q. Did you review records not listed in your affidavit?

A. No, I did not.
Q. So you reviewed what was given to you by the defense?
A. That's correct.
Q. You didn't do any independent investigation on your own?
A. No, I did not.
Q. You didn't review any other reports or materials, again that were not given to you specifically?
A. The things I reviewed are in my affidavit.
Q. Okay. Let me talk a little bit about your affidavit and get into some specifics.
How many questions are on the Michigan Alcoholism Screening Test?
A. Approximately 28. Twenty-eight, I think.
Q. And the Drug Abuse Screening Test is 20 questions?
A. Twenty-eight as well.
THE COURT: Let me just ask a question about that while it's on my mind.
THE WITNESS: Sure.
THE COURT: If I want to take the MMPI or the Myers-Briggs for example, I have to take it with somebody who's got the right to administer it. What about the MAST. Is it on line?

THE WITNESS: The MAST is on line, you could get it as well as the DAST.

THE COURT: Go ahead.

Q. Looking at your affidavit, in paragraph 14 that you have in front of you there -- I'm sorry just want to back up one second. Paragraph 13. I believe that's on page 7 of your affidavit. In there, you talked about this on direct examination, you talked a lot about Mr. Landrum's background and family and how that affected him later in life. Is that fair to say?

A. Yes.

Q. Are you aware that the defense in mitigation tried to show that Mr. Landrum in fact had a good family background?

A. I know that when I reviewed the transcript, that there were statements that certain parts of his life were good, yes.

Q. Don't you think the testimony that you're proposing here today would conflict with what that trial strategy was, that he came from a good family?

A. Again I can't comment on trial strategy.

Q. Okay. You also testified fairly extensively about Mr. Landrum's addictive disorders and the effects on him. I'm going to get into that in a little more detail, but are you aware also that

defense argued in mitigation that Mr. Landrum did have a background with serious drug and alcohol abuse?

A. I know that they mentioned that he abused those substances, yes.

Q. Looking at paragraph 14 of your affidavit, and again you talked about this a little bit on direct, Mr. Landrum's time at the Fairfield School for Boys and his time that he was in the Navy. How long was he at the Fairfield School for Boys, do you know?

A. I don't recall offhand.

Q. It's fair to say from your review of those records that's a pretty structured environment, it's not an open school?

A. Very structured environment, yes.

Q. But he graduated; correct?

A. He completed that school and had very good grades there.

Q. Got good grades, got a diploma. Got a driver's license, too, didn't he?

A. That's correct.

Q. Is it fair to say that he did fairly well while he was there for a substantial period of time?

A. I thought that he did exceptionally well there. I was very pleased to see his response to a structured environment without alcohol and drugs.

Q. Let's talk a little bit more about the alcohol and drugs, and specifically at the time of the crime. Do you know how much Mr. Landrum weighed at the time of the crime?

A. Not offhand. I know that he's always been small in stature.

Q. Is it fair to say that your body mass and weight affects the ability, or affects how drugs and alcohol react within your body?

A. Yes. What we know is the smaller the individual, the less it requires for an individual to become intoxicated. So someone smaller in stature would require a smaller amount of actual drug in order to be impaired and intoxicated.

Q. But you're not sure what his body weight was at the time of the crime?

A. Not exactly. I mean I know that he was small in stature. That was documented throughout the medical records that he was always rather small, and with that in mind, the amount of alcohol, even if he had been a large person, based upon the transcript indicating that he had 12 to 18 beers and somewhere around six to eight Ativan would have been enough for a person who weighed 250 pounds to be grossly intoxicated.

Q. Okay. Your affidavit, also your direct testimony

was that you concluded influence of alcohol and sedatives was prominent in Mr. Landrum at the time of the crime; is that fair to say?

A. That's correct.

Q. Would that affect his memory of the events at that time?

A. Absolutely.

Q. Are you aware that Mr. Landrum testified at trial?

A. Yes, I am.

Q. Are you aware that he testified in some detail about going into Mr. White's apartment and what happened?

A. That's correct.

Q. It's fair to say he had a very clear memory of what's going on?

A. I don't know that at all.

Q. In fact, Landrum on cross-examination by the prosecutor said that he knew what he was doing and it was hard to forget what had happened. Did you read that part of the testimony?

A. Yes, I did.

Q. Mr. Landrum also testified about him and Mr., he and Mr. Swackhamer's drinking a case of beer. In fact you talked about this a little bit on direct, that he

had taken eight Ativans and had consumed approximately 14 to 18 beers before the crime. Landrum are you aware testified that he had been drinking beers about every five minutes before the crime?

A. Yes.

Q. Is that consistent with someone with the diagnoses that you provided?

A. Yes.

THE COURT: Hang on just a second.

Okay.

Q. Pretty fast drinker, isn't he? Drinking a beer every five minutes is a pretty fast drinker?

A. It's very fast for a social drinker. Again you have to think about a person who is a heavy drinker, an alcoholic. I have seen alcoholics to drink two cases of beer a day, fifth of whiskey and a case a beer a day, so no.

Q. Okay. I want to talk about paragraph 18 of your affidavit. I'm going to break this down just a little bit. You concluded within a reasonable degree of psychological certainty that he was dependent on alcohol, sedatives and cannabis at the time of the offense?

A. That's correct.

Q. And that he was under the influence of alcohol

and sedatives at the time of the offense?
A. That's correct.
Q. And I'm just reading from -- that he was suffering from a depression called dysthymic disorder?
A. Disthymic.
Q. Thank you. And that was exacerbated by the use of alcohol and sedatives, and that he was in a state of diminished capacity.
Are you aware that the State of Ohio doesn't recognize the defense of diminished capacity?
A. I think I've read that.
Q. Okay. Is it fair to say that your conclusion that Mr. Landrum didn't understand the situation and that his judgment was inappropriate is based on the -- Let me strike that. Start over again.
Mr. Landrum, in your opinion, did he know right from wrong at the time of the crime?
A. I believe that he knew that he was committing a robbery and that was going on.
Q. Do you believe that he knew that he was committing a murder? If he was committing murder would he know that he was doing it?
A. I don't know that there was deliberation to commit a murder so I don't know about that.
Q. But there was a lot of deliberation before the

murder; correct?
A. Well, there was to break into his home and to rob it. There was planning for that.
Q. In fact, there was a lot of planning. That's when he was intoxicated; right?
A. Again I don't know what a lot is, but I know there was planning and that occurred while he was using substances.
Q. We'll walk down it. He armed himself with a railroad bolt before he went there. He had the foresight to gather a weapon of some kind; correct?
A. I know that he had a railroad bolt, or someone did. I don't know that he brought that or who brought that.
Q. He and Mr. Swackhamer cased the apartment before they went there; right?
A. That's my understanding. (Witness nodded.)
Q. Okay. He had the foresight to wear surgical gloves during the burglary?
A. Correct.
Q. He told Carolyn Brown that he would kill the victim if the victim returned; right?
A. I've heard of that. I don't know about that.
Q. Well, the Ohio Supreme Court found that in their factual findings. Were you aware of that?

A. That could be.
Q. Okay. He waited for White to leave the apartment. You are aware of that?
A. Yes.
Q. He was given the -- When Mr. White returned, Mr. White, according to the Ohio Supreme Court said something along the lines of, what are you doing, get out of here, and Mr. Landrum didn't leave?
A. That's correct.
Q. So all those things kind of indicate some level of understanding of what's going on. Isn't that inconsistent with your opinion that he didn't understand the situation?
A. No.
Q. Despite the fact that he did all these things up to the time of the crime?
A. That's correct.
Q. What do you think would have been an appropriate judgment in that situation? You say Mr. Landrum didn't utilize appropriate judgment. What would have been appropriate judgment?
A. Well, again I think that what we're looking at is the difference between the ability to think and the ability to think in a logical and in a sort of higher order thinking. Certainly Mr. Landrum was thinking.

He's not unconscious, he's not mentally retarded, he's making a plan to do something, but doing it and doing it well are two different things. And clearly he waited for the victim to leave to rob the house and then everything went wrong from that point on.

I would suggest that had he not been depressed, not been under the influence of alcohol and drugs, that his response to the situation might have been much different.

Q. Do you think most people not having Mr. Landrum's condition that are in a situation where they're burglarizing an apartment, are surprised by the owner, wouldn't react in kind of a panicked kind of reaction?

A. I think that would be part of it, and I think adding alcohol and drugs to depression only makes it that much worse.

Q. Okay. You talk about his inability to comprehend the situation. What do you understand the situation to have been at the time Mr. White came back into the apartment?

A. I didn't say that he was unable. I said it was impaired.

Q. His ability to comprehend the situation was impaired?

A. Correct.

Q. What do you understand is the facts that actually took place when Mr. White was murdered?

A. Again I don't know all the facts because I don't have that in front of me at this point. But what I do know is the cognitive functioning of Mr. Landrum at the time, and it's one of those things where it's not really about something willful. If someone injects certain drugs, they have an effect. If someone has a psychiatric disorder, it has symptoms. And the problem with those things, they don't go away. They're persistent, they're present.

So a person with depression, those symptoms will be present. If you have injected these drugs, within a period of time they're going to have the effect they have. And so we know that his cognitive functioning must be impaired given what he injected only several hours prior to the offense.

MR. FULKERSON: If I can have just a moment?

THE COURT: Sure.

Q. You gave Mr. Landrum an MMPI; correct?

A. That's correct.

Q. And that was the second version?

A. Uh-huh.

Q. The court reporter is taking everything down.

A. Yes.

Q. Did you do a validity determination on the MMPI that you gave Mr. Landrum?
A. It has validity scales and reliability scales, and those indicated that the MMPI was both reliable and valid.
Q. Did anyone else review the MMPI that you gave Mr. Landrum? Has anyone else ever reviewed it?
A. I'm not aware anyone has.
Q. You have given MMPI tests to people in the past in this context, capital cases. Has anyone ever looked at your results and determined they were invalid, the test was invalid?
A. Looked at the test that I gave that I said was valid and then they found it to be invalid?
Q. Correct.
A. No.
Q. Okay. You didn't give Mr. Landrum a Symptom Checklist test, did you?
A. No, I did not.
Q. You didn't give him an Impact of Life Events test?
A. No.
Q. And you didn't give him a Millon Clinical Multiaxial test?
A. MCI. No, I did not.

Q. Do you need to give those tests to do a thorough examination in this context?
A. No. Many of those would be competitive and result in possible invalidity of the test.
Q. Did you diagnose Mr. Landrum with a social personality disorder?
A. No.
Q. Have you ever diagnosed anyone in a capital context with an antisocial disorder?
A. Absolutely.
Q. You have testified in several of these cases; correct?
A. Where I found them to be antisocial?
Q. Just in general, you have testified in several capital cases in this context?
A. Yes, I have.
Q. Would you characterize Mr. Landrum's family life growing up as dysfunctional?
A. Yes.
Q. Isn't it true that not everyone that comes from a dysfunctional family suffers from the kinds of disorders Mr. Landrum does?
A. I think the problem is taking the term dysfunctional and applying it to all families. Individuals who come from Mr. Landrum's dysfunctional

background will present with the symptoms that he has.
Q. Okay.
THE COURT: Unless he gets treatment, or regardless of whether he gets treatment?
THE WITNESS: It will depend upon the type of treatment. Part of the difficulty that I had as a professional was reviewing the Upham Hall records. It was very disappointing to see that they referred to his alcohol and drug abuse repeatedly, yet there was nothing in the treatment plan to address the alcohol and drug addiction.
Q. On the MMPI test that you gave Mr. Landrum, did you disregard any of the answers to any of his questions when you scored the test?
A. No.
Q. Have you ever given an MMPI where you have disregarded answers to questions before that didn't --
A. I'm not sure. Do you understand the MMPI?
Q. Let me ask this. Have you ever -- you have given MMPI's in other contexts; correct?
A. I have given MMPI's throughout my career. In fact my research is on the MMPI.
Q. In giving an MMPI test, have you ever looked at the results and thrown out questions that suggest things that are inconsistent with your diagnosis?

A. Absolutely not. That would be both unethical and inappropriate. In fact you can't even determine what questions are going to be used or not used. That's not the way the MMPI is scored.

Q. You're saying that you have never --

A. It's not based on individual items.

Q. Pick and chose?

A. The whole idea is that the MMPI is 76 or 77 items and it's based upon profiles, not on individual items. And taking items out, any items out based upon the clinician's determination, would be inappropriate. The only time that you ever look at items individually are what are called the critical items of the MMPI.

Q. What are critical items?

A. Critical items are items that suggest very severe pathology. Suicidal ideation, alcohol, drug addition.

MR. FULKERSON: Can I have just one moment, your Honor?

THE COURT: Of course.

MR. FULKERSON: Thanks.

Your Honor, there will be no further questions.

THE COURT: Redirect?

MR. SIMMONS: Yes, your Honor. Very briefly, I promise.

REDIRECT EXAMINATION

BY MR. SIMMONS:

Q. I just wanted to be sure if I haven't already covered this, Doctor. We have in this case as Exhibit 3 an affidavit of Jill Miller, which I'm sure you've seen, I know you've seen. And a confidential memorandum attached to it that she did and submitted as part of her post-conviction proceedings in state court. You are familiar with those?

A. Yes.

Q. Were those important documents for your analysis?

A. Those are very important. Oftentimes they are summaries affidavits that are provided regarding interviews that were done with family members and friends that I would then rely upon as additional data to corroborate or not corroborate opinions that I have.

Q. That's all I have.

THE COURT: Anything further based on that?

MR. FULKERSON: No, your Honor.

THE COURT: I have a couple things myself.

EXAMINATION

BY THE COURT:

Q. Maybe just one area. I think you've said that you believe that Mr. Landrum panicked when Mr. White

returned, and that that panic was exaggerated by the effect of the alcohol and Ativan that he had consumed. Did I hear you correctly?

A. I think that his response was not a logical response but was a reaction, not a thought-through action but a reaction to the situation that then was based upon an impaired mind that's been sedated by both alcohol and Ativan.

Q. Is it at all likely that a person in those circumstances when reacting would chose a pattern of action that he had proposed before?

A. That would be a possibility. I think that some of it has to do with -- what's going through my mind is that Mr. Landrum has no history of violence that we're aware of.

Q. No history of violence at all?

A. Right.

Q. The point I'm adverting to is his statement prior to the murder during the course of planning the robbery, that if Mr. White comes back, I'll kill him. He may have been rehearsing that in his head.

A. Again I wouldn't want to speculate about what was going on in his head. When people are intoxicated or sedated, thoughts tend to not be as logical and flow as smoothly as we would expect or anticipate, so that

oftentimes there's missing logic, there's missing, sort of sequential thinking. And again it's more reaction to an event rather than I'm thinking about.

Q. Right.

A. He denies saying this so I don't know.

Q. Right.

A. That statement, I'm not sure what it means.

Q. You may step down.

A. Okay. Thank you.

(Witness excused.)

THE COURT: I believe that concludes the testimony to be presented in this matter, and so the next question is briefing schedule.

MR. SIMMONS: Could we move to admit the exhibits, please?

THE COURT: Of course.

MR. COLLYER: Your Honor, just for the record, we're going to object to the exhibits to the extent there are witnesses they did not call and could have called for purposes of this hearing, and we would rely on Williams vs. Coyle for that. That is inadmissible. When the Court orders an evidentiary hearing even though these are exhibits admitted to the state court, if these witnesses are available then those affidavits and reports are

MR. WILLE: Thank you.

(Messrs. Lazarow and Mezibov conferred privately.)

MR. LAZAROW: No further questions, Your Honor.

THE COURT: Is this witness released?

MR. LAZAROW: Yes, Your Honor.

MR. WILLE: Yes, Your Honor.

THE COURT: Thank you very much, Mrs. Leahy.

(Witness excused.)

THE COURT: Call your next witness.

MR. MEZIBOV: Dr. Parran.

THE CLERK: Raise your right hand, please.

(Duly sworn by the Clerk.)

THE CLERK: Thank you. Please be seated.

THEODORE V. PARRAN, JR., M.D.

a witness herein, having previously been sworn, testified as follows:

DIRECT EXAMINATION

BY MR. MEZIBOV:

Q. Good morning, Dr. Parran.

A. Good morning.

Q. Dr. Parran, before I begin to ask you any questions, the first thing I would ask of you is that you state your full name and spell your last name for the record, please.

A. My that is Theodore Van Doran Parran -- P-a-r-r-a-n -- Junior.

EXHIBIT 63

Q. Dr. Parran, where do you reside?
A. I live in Shaker Heights, Ohio.
Q. And could you tell us your occupation, please?
A. I'm a physician.
Q. And a physician licensed to practice medicine in the State of Ohio?
A. In Ohio, yes.
Q. Dr. Parran, could you give us the benefit of your educational background?
A. I went to college at Kenyon College in Ohio, and then went to medical school at Case Western Reserve University, School of Medicine; graduated in 1982. I did my residency in internal medicine for three years at Johns Hopkins Hospital, in Baltimore City Hospital, in Baltimore, Maryland, and I spent an additional year as a medical chief residence there, so that is my formal education and training.
Q. And, Dr. Parran, could you give us the benefit of your professional experience as a physician since the time you graduated from medical school?
A. Yes, having graduated from medical school, as I mentioned I spent four years in residency training in Baltimore. I then spent another two years living in Baltimore working on the faculty at Johns Hopkins School of Medicine and helping to direct both the general internal medicine Clinic as well as a drug and alcohol treatment program in Baltimore City

Hospital. In 1988 I moved back -- I moved back to Cleveland, taking a faculty position at Case Western Reserve University School of Medicine in helping to direct both the general internal medicine Clinic and several drug and alcohol treatment programs and consultation programs in the Greater Cleveland area.

Q. And where are you employed at the present time?

A. Currently I'm employed part-time by Case Western Reserve School of Medicine as the Director of the Clinical Science Program as well as the Director of the Addiction Medicine Pellowship Program. I'm also employed part-time by the Cleveland V. A. Medical Center helping to -- as the Medical Director of their extensive Drug and Alcohol Treatment Program. And then finally I am part-time or privately employed as a member of a group practice of two of us providing addiction medicine services to hospitals and substance abuse treatment centers in Cleveland.

Q. How long have you been working at the V. A. at Cleveland?

A. I started working at the V. A. in 19 -- 1993. In 1993, we applied through the V. A. for a grant to support our addiction medicine fellowship program and that was funded as one of only six in the country, and have been employed part-time with the V.A. since then.

Q. Dr. Parran, over the course of time have you developed certain areas of specialization in the practice of medicine?

A. Yes, I'm board certified in internal medicine and I continue to practice, a small percentage of my time, in general internal medicine. I'm also certified by the American Society of Addiction Medicine in the area of drug and alcohol dependence and treatment. And I honestly spend the majority of my time working in the area of substance abuse treatment, as well as researching, education in the area of addictions.

Q. When you say "majority" of your time, could you assign a percentage of your time to that area of practice?

A. Probably 70 percent at this point.

Q. What is the American Society of Drug Addictions?

A. The American Society of Addiction --

Q. Addiction Medicine. I'm sorry.

A. Yes. It's a multi-disciplinary group of physicians, about 4,000, maybe 4500 members. Approximately 3,000 of us are certified --

Q. How do you become certified?

A. -- of the organization.

In order to be certified in addictions medicine, you have to be able to provide documentation that you have worked full-time in the area of drug and alcohol dependence treatment for at least two years, and then you have to take a certification examination.

Q. Now, you have treated, I take it, individuals who have

been addicted to alcohol or drugs?
A. Yes. Since -- since 1985, I've treated somewhere between 1200 and 3,000 patients a year, each year, with a history of addictions, approximately split 50/50 between alcohol dependent and drug dependent.
Q. Dr. Parran, in addition to the board certifications that you've told us about, are you a member of any professional boards or associations or organizations?
A. Yes, I'm a member, as I mentioned, of ASAM, the American Society of Addiction Medicine. I'm also a member and have in the past served on the board of the -- of an organization called AMERSA, which is the Association for Medical Education and Research in Substance Abuse. I'm a member of the Society for General Internal Medicine. I'm a fellow in the American College of Physicians. And I am a fellow and a member of the Executive Committee on the American Academy of Physician and Patient.
Q. Now, Dr. Parran, have you over the course of time published any books or writings or treatises or studies in your particular areas of specialization?
A. Yes, I have. I've written, oh, probably more than a dozen maybe, close to two dozen but at least a dozen papers, book chapters, syllabus modules on the treatment of addictions, screening for chemical dependency, screening for chemical dependence, how to present the diagnosis, how to

form a treatment plan with patients, management of detoxification and the acute effects of drugs and alcohol, syllabus materials on cocaine dependency, prescription drug abuse, et cetera.

Q. Finally, Dr. Parran, have you had occasion before today to testify in court in matters in which you are a specialist or in areas in which you practice?

A. Yes, I have. I've testified in both criminal and civil proceedings in the area of management of chemical dependency and/or addiction medicine, especially in the area of the management of acute drug induced delirium. That was a civil case. In the area of prescription drug abuse and stimulant abuse, especially diet pills, those have been criminal cases.

Q. And, Dr. Parran, at my request did you bring down to us today a copy of your current CV?

A. Yes.

(Mr. Mezibov distributing documents to the Court and counsel.)

Q. Dr. Parran, I've handed you what's been marked Plaintiff's Exhibit 14. Can you identify that for us, please?

A. Yes, it's my C.V. which was updated last summer.

Q. So this is current up through the summer of '96?

A. It's at least current through, oh, probably July of '96.

Q. Now, Dr. Parran, let's turn our attention to this matter

involving John Hicks. Could you tell us when you were first hired by myself and Mr. Lazarow in connection with this matter?

A. It probably was either late 1994 or early 1995.

Q. And do you recall what we asked you to do initially?

A. Yes, you asked me to look at the data about the case, especially the information that was gathered around the time of the events in early August of 1985, in order to form an opinion about whether or not cocaine played a role or appeared to have played a role in those events. And, secondly, you asked me to look at the trial proceedings and the testimony to see if I could form an opinion about the quality of the information there regarding the pharmacology of cocaine and how it might relate to this case.

Q. And, Dr. Parran, could you tell us how you went about conducting your evaluation in connection with these matters which we asked you to look into?

A. Yes. I read through a sort of summary or excerpts of both the police investigation, the police interviews, and then some of the testimony in terms of pretrial, trial and mitigation proceedings.

Q. Were you provided the actual trial transcripts then?

A. Yes. Yes. And I was able to look at some notes taken by Ms. Leahy. I was able to look at the affidavits of a couple of different physicians or a couple of different doctors. I

can give you the doctor's name if you want.
Q. Is that Dr. Baum?
A. Yes, Dr. Baum.
Q. And Julia Hawgood?
A. Hawgood, yes.
Q. Psychologist?
A. And I was able in July of 1995 to actually go in and interview Mr. Hicks. And, finally, I received the depositions of Dr. Schmidt --
Q. Schmidtgoessling?
A. 'Goessling, and Doctor -- starts with an R.
Q. Reardon?
A. Reardon.
Q. All right.
A. Yes.
Q. Could you tell us when you interviewed Mr. Hicks?
A. It was in July of 1995. I don't remember the exact date.
Q. Okay. And could you tell us approximately how much time you spent with Mr. Hicks?
A. About an hour-and-a-half.
Q. And what was the purpose of your speaking with Mr. Hicks?
A. I wanted to have a chance to talk with him both about his previous experiences with cocaine prior to the events of August of 1985, to speak with him about how cocaine tended to affect him when he was using it, to get at least his

recollections of that point in 1995 of what went on in August of 1985, and, finally, just to get my own sense of him and his mental status, perhaps psychological or psychiatric background. Although my background is in internal medicine and not in psychiatry or psychology, I spend lots of time interviewing people with issues in those areas and I wanted to get a chance to interview him myself about those kinds of things.

Q. Dr. Parran, when you were provided these materials -- the trial transcripts, the affidavits and depositions and then actually speaking with Mr. Hicks in person -- were there particular matters you were looking for in order to aid you in your evaluation?

A. I was looking for specific descriptions of his mind state, his thinking processes, his sensations when under the influence of cocaine both prior to August of '85 as well as in August of '85, and any descriptions or evidence from interviews that he had provided at that time that might give some evidence or some clue from a clinical standpoint to me as to what state he was in.

Q. At the time these offenses were committed?

A. Yes.

Q. Now, over the course of looking at these materials and speaking with Mr. Hicks, were you able to find any credible evidence of drug use or its effect in connection with

Mr. Hicks?

A. Yes, absolutely. His history that he provided to interviewers, provided to me as well, the history that his family members had been able to provide to interviewers, as well as some records from previously mandated court -- or court-mandated treatment from the chemical dependency standpoint, all indicated Mr. Hicks had had a significant addiction problem in the past.

Q. You used the term dependence, cocaine dependence. Can you tell us what that means from your standpoint?

A. Well, there's sort of an over-arching view or diagnosis we use of chemical dependency, which means the person meets a certain criteria in DSM-IV -- which is the Diagnostic and Statistical Manual-IV edition -- criteria for what would be called in the vernacular "addiction."

Chemical dependency -- in this case dependency to cocaine and alcohol -- includes: Compulsive use; use to levels of intoxication that weren't planned; adverse consequences from repetitive use; loss of control of use once initiating that use. So a person, as long as they haven't used any of the drug in a given day, tends to be fairly predictable; but when they do it again, they tend to lose control and over use, resulting in adverse consequences.

(Continuing) Increase in preoccupation with use; use despite repetitive and multiple, as I mentioned, adverse

consequences; sometimes increased tolerance, and at times physical dependence, including withdrawal from the drug when it's taken away -- although, I must say that 80 percent of people who meet the criteria for a diagnosis of chemical dependency or addiction don't have physical dependence to the drug, meaning they don't use it every day and they don't go through withdrawal when they stop using it.

Q. What you've just listed, are those objective signs and symptoms of chemical dependency?

A. Yes, they are objective. They're verifiable. They're primarily based on history. But a careful history taken from an individual can generally rule in or rule out chemical dependency.

Q. Did you find signs and symptoms of cocaine or chemical dependency in connection with Mr. Hicks?

A. Yes, absolutely.

Q. Can you describe to us what those objective signs and symptoms of chemical dependency was or were?

A. Yes. Mr. Hicks' background with alcohol and drug abuse -- primarily marijuana early on -- resulted in repetitive adverse consequences in his life from a performance standpoint in school, from a performance standpoint at work, from a financial standpoint, and from a legal standpoint from his late teens on.

He, during periods of less use or abstinence, tended to

function quite well, and at times of increasing use developed, as I mentioned, repetitive adverse consequences resulting in pain and suffering in his life as well as in those surrounding him.

Sometime in, the best of my recollection, the late '70s/early '80s, Mr. Hicks' drug of choice seemed to switch from alcohol and marijuana to cocaine and alcohol. And he developed, I think, inarguable evidence of cocaine addiction, including in 1982 or '83 going through a significant amount of money -- several thousand dollars that he had in a retirement fund -- in cocaine use, and actually in the year of 1985, earlier that year, going through probably a couple thousand dollars in his bank account and his wife's bank account for cocaine use. So that indicates cocaine dependence to me.

Another thing that indicates cocaine dependence is actually the way he tends to use. Initially, he started to use cocaine by snorting it, and fairly soon shifted to using I.V. And the data about cocaine use and the routes of administration indicates that of the 35 million Americans or so who have intermittently tried cocaine, there's about three million or three-and-a-half million, 10 percent, that develop cocaine addiction or cocaine dependence. And the vast majority of those who shift from intermittent use of cocaine, what might be casual use of cocaine and cocaine dependence,

tend to change their route of administration. They either use an I.V. or, more recently now, smoking the cocaine.

So, when I see a person who has a history of shifting their route of administration to an I.V. form, that is powerful evidence of a move to addiction.

And then, finally, the pattern with which he tended to use. He tended to use an intermittent binge pattern of cocaine. And, once again, people who are casual users or occasional users of cocaine tend to use it casually and occasionally. People who tend to lose control of cocaine, like most other stimulants that we have experienced with over the last hundred years or so, tend to shift to a pattern where they intermittently binge on the cocaine where they initially use it, and then use it several times to multiple times over the next few hours to few days until their money runs out, or they become too paranoid, or they become too exhausted, and then they sort of quit using the cocaine and crash and go to sleep and sleep off the binge. And it tends to be a -- sadly, sort of a payday phenomenon where people get paid on Friday and have strong urges and connect the use of cocaine with the handling of money, and then people tend to binge in the middle part of the week, recover on the weekend to go to work on Monday.

Q. What you describe, is that a phenomenon you observed or found in the history of Mr. Hicks?

A. Absolutely.
Q. Now, can an individual feign or fake cocaine dependency or chemical dependency?
A. No, not really. It's -- it's really not possible to fake addiction to the point of spending several thousand dollars of a retirement fund in a matter of several weeks to a couple of months intermittent binging on cocaine and then earlier in 1985 a couple of thousand dollars' worth of the entire bank account of oneself and one's spouse. That is just not a pattern that people are able to put on.
Q. What was the significance of this history that you found with regard to Mr. Hicks in your evaluation that we asked you to do for us?
A. Well, the history that I found with Mr. Hicks in terms of his shifting from marijuana to cocaine, people who have previously been dependent on marijuana -- which is a sort of a small scale or fairly weak stimulant on the dopamine system -- a person who's been a habitual dependent or addicted marijuana smoker, if they start using cocaine, tend to in a high percentage of cases, I would say 85 percent of the time, develop cocaine dependence, and it's certainly what happened to Mr. Hicks.
Q. You mentioned the dopamine phenomenon. What is that?
A. Uh-huh. Cocaine has three primary effects in the body, three primarily pharmacological effects. It's first effect

is to basically short circuit the peripheral nerves. It blocks the sodium potassium-pumping peripheral nerves and, therefore, it is a very good anesthetic, and cocaine is used as a local anesthetic. Since the peripheral nerves are short circuited, they can't transmit pain sensation and so they become deadened or numb, the area where it's applied.

The second effect of cocaine is systemic effect, a through-the-body effect, and that is a blocking of the reuptake of norepinephrine and also to some degree stimulating the release of norepinephrine.

Q. And norepinephrine is?

A. Norepinephrine is known in the vernacular as adrenaline, a hormone, a systemic hormone released by the adrenal gland which tends to stimulate increased heart rate, increased blood pressure, increased reflexes, decreased appetite, gets rid of a need for sleep, so people don't sleep and they don't eat and they're all jazzed up. And the rush of cocaine, the -- what's described as the initial rush of cocaine, is a norepinephrine or adrenaline surge.

The third effect of cocaine is a central effect in the central nervous system where cocaine blocks the reuptake of dopamine and it also stimulates the release of dopamine. Dopamine is a neurotransmitter.

Q. A neurotransmitter is what?

A. A neurotransmitter -- a neurotransmitter is a chemical

release by one nerve or neuron in the brain which then stimulates a second nerve or neuron in the brain and produces a reaction or a feeling. And dopamine is the -- is the neurotransmitter which produces euphoria in the human brain. For example, on the first sunny, warm day in spring, if we were able to measure dopamine levels in our brain compared to the last snowy, cold day in February, all of our dopamine levels would be a little higher because our spirits would be a little higher because of that external stimuli.

Q. Spring fever actually has a physiological effect?

A. Clearly. Absolutely. Dopamine is deficient, or the brain is relatively immune to normal levels of dopamine when people have clinical depression and, therefore, most antidepressant medications work either directly or indirectly to intensify the brain's sensitivity to dopamine so that our spirits are lifted and the depression eases. Dopamine honestly is released during any pleasurable experience.

Cocaine is the most potent drug that's been identified which blocks the reuptake and stimulates the release of large amounts of dopamine in the brain, and, hence, it produces variant euphoria. So, pretty much all addictive drugs that we know of, from nicotine to marijuana, from heroin to cocaine, including things like alcohol and Valium and even prescription pain medications, all either directly or indirectly increase dopamine levels in the brain. Dopamine

is clearly a final, common pathway of addictive drugs.
Q. Now, Dr. Parran, what I'm going to ask you is this question: Based on all of the materials you were provided which you reviewed in connection with this matter, and drawing on your professional experience and knowledge, do you have an opinion, to a reasonable degree of medical certainty, whether Mr. Hicks was cocaine- or chemically dependent at the time he committed the offenses in question?
A. Yes, he certainly was cocaine dependent and alcohol dependent and, hence, he had chemical dependence with a drug of choice, of cocaine, and a secondary drug of choice, of alcohol -- that would be the current terminology we use clinically.
Q. You described how the cocaine affects an individual pharmacologically; correct?
A. (Nods head affirmatively.)
Q. Could you tell us what cocaine psychosis is?
A. Yes. I just described the sort of three pharmacological effects of a single dose of cocaine: Peripheral nerve numbing, of how the drug was administered, and then sort of systemic rush of a surge of norepinephrine, and then central release of dopamine and euphoria. That's what happens when anyone takes a single dose of cocaine.

As people take more and more cocaine, as people repetitively administer cocaine, several things happen: Less

and less dopamine is released because the dopamine nerves in the brain only have a certain supply. Since the cocaine stimulates too much release of dopamine and doesn't let the nerve take it back up to recycle it, the nerve becomes depleted of dopamine and, hence, subsequent administrations of the drug produce lower and lower amounts of euphoria. At the same time when the drug wears off, people have what is called dysphoria, or a hangover. It's almost better to grasp --

Q. Is it easier to chart that?

A. The euphoria -- it would be easier to draw it out.

MR. MEZIBOV: Your Honor, may I use the chart?

THE COURT: We'll recess and he can draw his diagram.

MR. MEZIBOV: Thank you, Judge.

THE CLERK: All rise.

(At 10:12 a.m., a brief recess was taken.)

* * * (10:35 a.m.)

THE COURT: Is the petitioner ready to proceed?

MR. MEZIBOV: Yes.

THE COURT: Respondent ready to proceed?

MR. WILLE: Yes.

THE COURT: Proceed.

BY MR. MEZIBOV:

Q. Dr. Parran, during the break you have prepared a couple

of exhibits for us; have you not?
A. Yes, I have.
Q. And we were talking about cocaine psychosis and the pharmacological effects of that.
A. Yes.
Q. Could you, with the Court's permission, come down and show us what you prepared for us?
A. Okay.
THE COURT: Proceed.
MR. MEZIBOV: Your Honor, with your permission. Maybe if we all came closer. Is it okay?
THE COURT: I can see.
MR. MEZIBOV: Okay.
(Witness positioned by the easel.)
A. What I've tried to graph out here is the effects that one might receive from the administration of a fixed dose of cocaine by two different routes.
What I've drawn in a solid line here, sort of this wavy shape, is the effect that one might receive from snorting or intranasally administering perhaps 10 milligrams of cocaine.
And along this axis here is sort of a person's mental state, base line, euphoria and dysphoria, and at the bottom end of dysphoria, paranoia.
And what I've drawn along this axis is time.
If a person snorts, for example, 10 milligrams of

cocaine, it takes about two minutes for a person to really start getting high. It's because cocaine is fairly slowly absorbed across the nose membrane and there isn't very much membrane in the nose to absorb it.

Also, we mentioned that one of cocaine's initial effects is to produce a lot of norepinephrine in the system, a lot of adrenaline in the system, and that causes a spasm of smooth muscles which closes down blood vessels. So, there isn't much blood to the nose when one snorts, so the cocaine is slowly absorbed. The peak euphoria is after 20 minutes. The total duration of euphoria is 40 minutes, possibly a little longer, possibly a little shorter, and then there is dysphoria, there is a hangover. And as with any mood-altering drug that a human self-administers, the euphoria is always followed by dysphoria. It doesn't matter if it is alcohol or nicotine or cocaine. And the intensity of the low is pretty directly proportional to the intensity of the high, to use the example of alcohol that many people are more familiar with. How intoxicated a person gets is proportional to their hangover. And it'd take approximately the same time to come back to base line from dysphoria to euphoria, that is, if you snort cocaine.

THE COURT: So the episode is 80 minutes?

THE WITNESS: Eighty minutes from snorting cocaine, yes. When you look at this kind of a curve, you see a curve

that actually resembles having a mixed drink at a party. A person, after a little while, gradually becomes a little disinhibited (sic) or euphoric. It wears off after a period of time with dysphoria and a person comes back to base line.

If you take those same 10 milligrams of cocaine, instead of administering intranasally, if you use it in an I.V. or if you smoke it -- it is just that the cocaine that was available in 1985 generally was cocaine hydrochloride, the acid form of cocaine, it was not smokeable. Cocaine carbonate (phonetic) or base, so-called freebase, is crack cocaine. This is what's marketed now and it is easily smokeable by changing it from its acid to base form, which most people cocaine dependent smoke it. Back in '85, most people with cocaine dependence couldn't turn cocaine hydrochloride into cocaine chlorate (phonetic) and smoke it, so they tended to use it in an I.V. And if you take the 10 milligrams of cocaine, if I had drawn it proportionally, this area below this curve here should be equal to the area under this curve here because it's the same 10 milligrams of cocaine. But what happens is this onset of the high begins in 15 to 30 seconds instead of two minutes.

THE COURT: That is I.V.?

THE WITNESS: I.V., or smoking. But for purposes of this discussion, I.V. It begins in 15 seconds; takes about that long for blood circulation to move through the arm

to the inferior vena cava to the lungs to the brain. It peaks at about two minutes. It is pretty much done, in terms of the measurable or reported euphoria, within about ten minutes, and then there is a very deep dysphoria that follows the very high euphoria, and then much more gradually the dysphoria comes back to base line.

Q. What is the impact or the dysphoria with respect to the paranoia that you've also outlined on the chart?

A. Well, if a person uses a small amount of cocaine I.V., they get very intensively euphoric for a short period of time and then their actual mood, their spirits -- this is what is called dysphoria, depression, despondency, lack of interest in anything in life, except perhaps using more cocaine is what sort of dysphoria would be defined as. And if the dysphoria gets deep enough, people tend to repetitively report paranoid ideation, paranoid feelings, and that will become more important when I show you the next graph which demonstrates multiple self-administered doses of cocaine.

The reason why I said if a person shifts to an I.V. form of cocaine from a snorting form of cocaine that it indicates to me addiction, is that when a person is this high, this is not a "social high." The high is so intense at this point that the human brain has a tough time processing other stimuli. When a person is this intoxicated, it's often considered a so-called social lubricant. When a person is

this intoxicated, it probably doesn't matter to the person whether they are at a party or isolated. It's just tough to interpret much else here. And then the low is so low, the hangover is so intense, that most social users of the drug, whatever that drug may be, if they're used to do doing this and they ever do this kind of intense experience with the drug, they say "This is too high. This is too low. The whole thing was gone too quick. I'll never do that again."

When a person has the disease of addiction, this is interpreted, this intense high is interpreted as Nirvana. And this intense low, by some strange neurochemical mechanism of addiction that we don't -- that we haven't identified yet, this intense low is actually interpreted by the addicted brain as a reason to use again now, which is the difference between social users of mood-altering substances and people with chemical dependency. It is clearly a brain lesion. It is clearly a disease of neurochemistry. But we don't know why this -- what would be a called a negative reinforcer, a reason not to do that behavior again -- is interpreted in the addicted brain as a reason to use now.

Q. Before we turn the chart, for purposes of the record we'll indicate that Dr. Parran has signed his name and initialed his first chart. We've marked that as Exhibit 15.

A. Seeing this sort of basic pharmacology of cocaine, sort of regardless of chemical dependency or not, this is the same

graph --

(New chart displayed.)

A. -- that typifies a cocaine binge or a person who repeatedly self-administers cocaine by the I.V. route, as is evidenced in this case.

Q. This is again marked Exhibit 16 and bears your initials and the date.

A. Yes. Yes. What happens is that the initial use of the cocaine produces an intense euphoria that goes away relatively shortly; but the dysphoria lasts a long time. The dysphoria tends to produce in a person with an addiction an overpowering urge to use again. And so they use again, but this time the place where they start from is actually at a low level, as opposed to a normal base line.

THE COURT: I'm sorry. This is your addict? Is this your addict? Are we dealing now with an addict?

THE WITNESS: Yes. A person with addiction, yes.

THE COURT: All right. And you say "a long time." How long?

THE WITNESS: The dysphoria after a single administration of cocaine can certainly last -- can certainly last 80 minutes.

THE COURT: Well, now on the other chart it was a short time, you told me.

THE WITNESS: The dysphoria peaks soon, but it has

a gradual tail.

THE COURT: But now you're changing it. You had it about 50 or 60 minutes, and now you're changing to 80 minutes. Aren't you?

THE WITNESS: Well, this is the dysphoria, or the -- or the intense low that people feel. They gradually come back to base line, but the craving for more cocaine is described to last -- to last significantly longer than that. But this is actually the low mood state, and this is 60 minutes, 50 minutes, somewhere in that range.

THE COURT: I'm just using your charts now.

THE WITNESS: Okay. That's fine.

THE COURT: So, the line, the diagonal line that you were just talking with before I interrupted you --

THE WITNESS: Yes.

THE COURT: -- is a 60- to 80 minute line?

THE WITNESS: Certainly an hour.

THE COURT: All right.

THE WITNESS: Certainly an hour.

THE COURT: So in Mr. Hicks' case, we're dealing now with the first hour?

THE WITNESS: This would be the first self-administration, so it would be about the first hour.

THE COURT: So the euphoria was felt again -- before the euphoria was felt again, we're dealing with an

hour of time?

THE WITNESS: I'd have to go back and look through the notes for exactly the period of time that was reported, but it's -- it's my recollection now that the first administration took place, and then within -- between an hour and two hours the second administration took place. And then once again there is some differing reports of between three and five injections; about an hour or so, maybe two hours, with a third injection, yes.

THE COURT: Proceed.

THE WITNESS: Okay.

A. (Continuing) What will typically happen in a cocaine binge is a person will use cocaine, they'll feel high, they'll feel very low. They'll grad -- their spirits will be very low here. They'll self-administer again sometime. When they self-administer again, the peak of the high is significantly lower than the initial, partly because they're starting from a lower base line state when they use again, but partly because there isn't as much dopamine in the original nerve as there was in the first place because so much was released in the initial -- in the initial use of the drug. And so you're dealing with a functionally dopamine-depleted nerve and, hence, it can't release as much dopamine. So, with the second administration, people never report being anywhere near as high as with the first

administration, and always report that the low is much lower than after the first administration.

So, if we have a second administration, at some point during that same binge, honestly these administrations in some cocaine binges are every 15 to 20 minutes. Sometimes they're spaced out by a few to several hours. Usually it's in the range --

THE COURT: When do they become fatal?

THE WITNESS: Cocaine -- cocaine binges actually are surprisingly rarely fatal, considering we have about three million people intermittently binging on cocaine per year in the United States. We only have about somewhere between a thousand and 1500 fatal overdoses from cocaine per year.

THE COURT: How much -- how much does that take? Or does it vary with the size of the individual? Or is it something that can be -- can't be determined except on a case-by-case basis?

THE WITNESS: It is a case-by-case basis. The reason being, because the fatality of cocaine tends to involve one of three mechanisms -- actually four; the most common I'll get to last. The first is spasm of the coronary arteries, smooth muscle in the arteries in the heart which spasm lead to a heart attack and then death. And that is just sort of an intermittent thing that is unpredictable.

Secondly, a seizure. And it's entirely unpredictable when a person can have a seizure associated with cocaine use.

Thirdly, rarely will people have a stroke from cocaine use, and it can be a large stroke and produce death. The most common way that cocaine produces death is suicide, and there's lots of suicides as well as homicides associated with this sort of bizarre paranoid behavior that begins when people are in the midst of a binge. We don't have good numbers on that. The numbers that I gave you of about 1500 people a year, maybe 2000, who die of cocaine overdoses are from heart attacks, seizures or strokes.

THE COURT: And you say that cocaine base leads to this episode that you've just described in Exhibit 16 more than just powder cocaine?

THE WITNESS: Actually, cocaine hydrochloride, powdered cocaine and cocaine base, rock cocaine or crack cocaine, are pharmaceutically the same thing. It's -- it's just that in order to get enough cocaine hydrochloride, the powdered cocaine, into one's system to experience this, it really has to be used in an I.V., and most Americans are terrified of needles and won't use an I.V. Cocaine base is pharmaceutically identical. It is just if you smoke cocaine, it is all instantly absorbed by the lung. The nicotine companies have known that any mood-altering substance that

can be volatilized or vaporized and, hence, inhaled, can be instantly absorbed by the lung and, hence, delivered pretty much directly to the brain, and so it's two different delivery systems for really, honestly, the same drug.

THE COURT: And it's only cocaine base that can be delivered to the lung?

THE WITNESS: Yes. Cocaine hydrochloride, powdered cocaine. If you heat it, you have to heat it to 400 degrees centigrade for it to burn, and then it actually burns and denatures, rather than vaporizes. Cocaine chlorate -- or what we know as crack cocaine, rock cocaine or base -- if you heat it, since it's in the base form, it vaporizes at a hundred degrees centigrade; temperature that is easy to reach in, you know, any sort of smokeable form. And, hence, since it volatilizes and vaporizes, it is able to be smoked, inhaled in the lungs and absorbed directly by the lungs, much like nicotine. And the -- I hate to say it, but the advantage -- but the advantage of delivering a mood-altering drug to the brain by the lung is that it's all absorbed into the lung immediately in a very small -- one heartbeat's worth of blood, when then in the next heartbeat it gets delivered to the left heart, which then in the next heartbeat is delivered to the brain. So, we're really talking from the time you smoke cocaine it is -- from the time you inhaled to the time the cocaine hits your brain is, for all practical

purposes, three to four heartbeats, and so it's an even quicker, more concentrated way to deliver a boulis of the drug to the brain, hence, it tends to, if anything, be even a little bit more reinforcing with even a little bit more acute onset and possibly a higher peak than using an I.V.

THE COURT: So, the use of cocaine base is more likely to result in an episode that you've described on Exhibit 16 than the use of cocaine hydrochloride?

THE WITNESS: The use of cocaine base is just as likely to produce this kind of a binging situation (indicating) as the use of cocaine hydrochloride I.V. And the use of cocaine hydrochloride by snorting, the intranasal route, tends to be less likely to produce this kind of a phenomenon.

THE COURT: And this episode you say results in violence or death?

THE WITNESS: Well, yes.

THE COURT: Violence against self, violence against others?

THE WITNESS: Especially with subsequent self-administrations. Each time a person uses, the high is less high and the low is even more low. With more and more dysphoria, more and more paranoia, more and more intrusive thoughts, more and more difficulty interpreting normal stimuli as being non-threatening. It tends to lead to people

arming themselves on often a regular basis, using more and more by themselves, being more paranoid in their ideation, misinterpreting external cues and participating in what everyone else would observe as unprovoked random violence.

THE COURT: As a practical matter, a user of cocaine -- "addict," if you will -- the only way they can use it or assimilate it is by self-administration; isn't it? There is only one to administer to?

THE WITNESS: No, I've interviewed lots of patients with positive toxicology tests for cocaine, all of which are certain someone slipped it in their drink. And when the story comes out, that doesn't happen.

THE COURT: Proceed. I'm sorry.

THE WITNESS: No. The important aspect with this kind of a graph is that as people in the midst of a binge with cocaine, repetitive self-administration of cocaine, as they become more and more dysphoric, the paranoia and then more clearly psychotic symptoms of cocaine psychosis become prominent. The estimates are that when people use cocaine I.V. or they smoke it, and if they use it in an intermittent binge crack pattern, the estimates are at least 50 percent and probably 70 percent of people develop significant paranoid ideation during the end -- during binges after the initiation, or binges lasting for a few to several hours after the end of a binge; 50 to 70 percent. One would say,

"Well, if this drug produces euphoria first and then all of this terrible dysphoria and more and more paranoia and after a while a person is using and not getting back to base line, why on earth do people continue to use it?" -- that is addiction. If I had an answer to that, it would be even simpler to treat people.

The paranoia, sort of the continuum from dysphoria to paranoia to psychosis with cocaine -- and it honestly is a continuum, almost like a continuum of white to black with many shades of gray in between -- is one which has clearly been identified and honestly was identified back in the early '80s as a phenomenon which was susceptible to something called the "kindling effect." And let me just describe the kindling effect and then I'll stop and answer questions, I guess.

The kindling effect was first identified in manic depressive disease or so-called bipolar disease, where it was observed that if a person had manic depressive disease, when they first developed it, their manic episodes would last a long time and not be real manic and they're depressive episodes would last a long time and not be very depressed. And as a person went through the cycling of manic depressive disease, it required less stimulation of a mania to bring upon a more and more intense depression and then less stimulation of a depression to bring on more an more intense

mania. And it seemed that person seemed to cycle more and more rapidly between mania and depression and it's been hypothesized as an electrical phenomenon in the brain called the Kindling phenomena.

It was next demonstrated in the early '60s in Lexington, Kentucky at the Addiction Research Center at the Federal Penitentiary for Drug Offenders that the Kindling phenomenon was clearly present in opium dependents. The way that they studied this is, they basically took federal prison volunteers who had a history of opium dependence and they gave them morphine for six weeks -- six times a day by injection and then they put them in a small room with bizarre wallpaper for five days and let them go through untreated withdrawal. And they took -- and morphine withdrawal lasts for five days. Then they'd take them out of that room and put them back in prison for six months with no morphine, and they would bring them back and just put them back in the room with bizarre wallpaper without any morphine, and 100 out of 100 patients would develop dilated pupils, runny noses, objective and substantive signs and symptoms of opiate withdrawal just being in the context where they had been in previously untreated withdrawal before. Sort of a Pavlovian learned response, one might say.

What was demonstrated in research in the late '70s and the early '80s with cocaine psychosis and with

cocaine-associated seizures is that clearly a kindling phenomenon is present with cocaine as well, especially in the area of cocaine-associated paranoia, cocaine-associated psychosis and cocaine-associated seizures. The earliest research was with the seizure in the late 1970s. They identified people tended not to have a cocaine-associated seizure unless they had been on an extensive binge, tremendous quantities of cocaine, a couple thousand dollars worth of cocaine on a weekend, and then they would finally surpass the level of cocaine toxicity in their system where they would have a seizure. And once they had that one seizure, subsequent use of cocaine to a much lower level -- just two or three or four administrations of cocaine -- could produce a seizure in the same person, where previously it had required 20 or 30 self-administrations. Once the wiring mechanism or the response of a seizure to cocaine intoxication had happened in those people's brains, it took less of an insult from the drug to produce the same effect.

What was then identified in the early 1980s is that it was exactly the same with cocaine-associated paranoia and cocaine psychosis. Then originally when people began using cocaine in an addictive way, it required a lot of cocaine, a heavy, heavy binge maybe for a day and -- a day or two days for a person to really start getting toxic from a paranoid and sort of psychotic delusional standpoint. But once they

had reached that, subsequently -- even if they had been off cocaine for six months or a year -- subsequently only a couple, three, four, five administrations of cocaine could produce similar paranoid and psychotic symptoms, a kindling phenomena, which was identified in the literature in the early '80s -- clearly in the early '80s but also in -- associated with amphetamine psychosis, and cocaine is scheduled as an amphetamine-like drug. The kindling phenomenon with amphetamine psychosis has been well known since the 1950s. I'll stop.

Q. Dr. Parran, I'm going to ask you to resume your seat, if you would.

(Witness regained the witness stand.)

Q. Dr. Parran, you've mentioned three central features, I believe, in this discussion here: One is cocaine psychosis; two is this concept of binging; and third is that of the concept of kindling, kindling effect.

Could you relate all of those concepts or phenomena with the history of John Hicks as you understood it from the materials that you were provided?

A. Yes. Certainly Mr. Hicks, his past history over the last three to four years prior to the crimes that were committed, demonstrated an intermittent binge-type dependence or addiction on cocaine. His pattern clearly was a binging-type pattern where he wouldn't use it for several days, often

several weeks; occasionally a few to several months. But then once he did use, he'd use repetitively and then try to stop it. And once -- once he had used, he used repetitively on that occasion and then he stopped it, but he'd only be able to be stopped for a short period of time and then he was repetitively again. Sort of a gradually accelerating intermittent binge pattern. Periods between binges got shorter and shorter. That certainly is what he described in his interview with Dr. Baum in 1990 and it is what he described to some degree in his interview with Ms. Leahy.

And certainly the descriptions that Mr. Hicks gave to Ms. Leahy as well as the detectives in Knoxville when they interviewed indicated there was a cocaine binge that he had -- that the events of August 4th or 5th, I can't remember which date it was, had the hallmarks of a binge: Hadn't used for a while, pay day, got paid, got his money, all of his plans for the day went out the window; used cocaine -- actually initially had a little bit of trouble getting the initial cocaine and started getting edgy and restless and irritable, used the cocaine, felt very high. As it went away, he got increasingly crescendo urgings or cravings to use more cocaine, again began to cast about on how to get money for more cocaine, et cetera. So, it's -- it's classic for a cocaine binge.

The paranoia, moving towards cocaine psychosis, is

actually there's some evidence in the interview done in Knoxville with the detectives that supports there being paranoia, intrusive thoughts, difficulty following through and maintaining one thought pattern, erratic, irrational, and uncharacteristic out-of-control behavior on his part is all there. Even in the interview it was concluded by people, you know, who will -- who are law enforcement professionals, not clinicians -- had clinicians been conducting that interview, I think several points would have been followed up on and a lot more data in the interview, but, I think there is clearly some data there and then much more data in the interview done by Ms. Leahy about the mental state or the thinking state, psychological state that Mr. Hicks was in after or during this binge of cocaine.

And then the kindling phenomenon also is -- there's some evidence for the kindling phenomenon in Mr. Hicks' history in the assessment done by Dr. Baum, the really good chemical dependency evaluation done by Dr. Baum in 1990, as well as some in Ms. Leahy's interview indicating previous sort of binging patterns and suspiciousness and paranoid ideation in the past when he had used the cocaine -- much more heavily in the past than at this time. So, I think there is evidence of all of that.

Q. Now, let me ask you -- let me ask you some ultimate opinions in a moment. But before I do, in looking through

paranoia comes on after the intoxication has worn off, when the dysphoria has kicked in, and it tends to get worse and worse with subsequent administrations. So, the dysphoria paranoia and psychosis tends to increase with subsequent administrations, whereas the intoxication tends to decrease with subsequent administrations.

And clearly the literature, both now and in the early 1980s, indicates that once this severe paranoia or cocaine psychosis begins, it tends to last for a matter of hours after the last administration of cocaine. It rarely, if ever -- and, frankly, lasts up until the time of the crash. What I teach medical student residents -- honestly, what I teach Emergency Room doctors, I have many talks about the cocaine-intoxicated and cocaine-agitated person. What I especially tell Emergency Room doctors, because they're the ones that see people in this state all the time, is when a person has been binging on cocaine, they're getting more and more agitated, paranoid, irritable, interpreting external stimuli as threats. They frequently also are experiencing tightness in the chest, chest pain, other things, so they often wind up in the Emergency Room. And when they come in, they're very dangerous and they need to be sedated immediately in order to -- in order to ensure the safety of the Emergency Room staff. Once -- what tends to happen is a person binges on cocaine for a certain period of time and then there is a

peri-binge period of a few hours, several hours. People are restless, irritable, paranoid, and then they crash. And the crash means basically going to sleep and sleeping it off and eating a lot, because in the midst of a binge, the norepinephrine effects of cocaine cause people not to eat and not to sleep. So, the recovery -- the crash from cocaine tends to involve hypersomnolence and hyperphasia: Eating a lot of things and sleeping a lot.

Rarely -- in fact, clinically it is almost unheard of now -- people still have some cocaine psychosis after they wake up at the end of the crash. Very, very rarely. But, typically, a fair number of people are paranoid right up until the time of the crash, of the time when they fall asleep.

When we look at -- at this case and we hear the descriptions of a single use, strong cravings to use more, hocking a VCR, erratic thoughts, commission of a murder, use of more cocaine, commission of another murder and sort of agitated period of time where a person is hypervigilant, goes home, sees their spouse, used some sedating drugs -- people frequently self-treat that agitated, restless time with things such as marijuana or alcohol, sedatives which were self-administered, and then leaving, driving, still being sort of irrational, crashing, going to sleep, waking up and driving to the police station and turning one's self in and

confessing, is classic for cocaine psychosis.

Q. Now, I think you've answered in a substantial way my next question, but let me ask you anyways: What are the outside signs and symptoms of cocaine psychosis?

A. Let me add -- I'll list a few things and then I'll specifically list a few things that are not described with cocaine psychosis which I think have shown up in some of the transcripts as confusing points. Cocaine psychosis, or -- cocaine psychosis is a phenomenon which is characterized by paranoid thoughts, misperceptions, intrusive thoughts. So the feeling, like thoughts are coming into one's head, suddenly having a thought, frequently irrational, intrusive thoughts, hallucinations, overwhelmingly tend to be either auditory, hearing voices -- although they're usually interpreted as thoughts as coming in their mind -- but hearing voices and tactile -- occasionally people feel what is called cocaine fleas, or feel things crawling on their skin, less and less ability to follow consistently through on a plan, more jumping and jumping from one plan to another and from one thought to another and more and more bizarre ways.

What typically is not present with cocaine psychosis is florid delirium. I mean, these people aren't talking out of their minds, acting, you know, bizarrely, schizophrenic or talking like they're in delirium or DTs, or whatever, but their thoughts and their behaviors are erratic and irrational

and frequently moving from being mildly paranoid, to being armed, to being actually violent.

Q. Now, were these classic signs and symptoms of cocaine psychosis present in the record that you have reviewed relating to Mr. Hicks?

A. Yes. I think as I mentioned there's evidence of it even in the interview with the detectives in Knoxville, although that interview was an interview aimed at an entirely different topic. I mean, it was a difficult task. Even given the fact it was, you know, a law enforcement, professional interview, there is evidence in that interview that some of this was going on, and a lot of evidence in the interview done with Ms. Leahy.

Q. And, Dr. Parran, do you have an opinion, to a reasonable degree of medical certainty, whether Mr. Hicks was in the throes of a cocaine psychosis at the time of these two murders?

A. Yes, I -- in reading the -- having read the transcript from the confession and having read the history of the client in terms of the past, my initial opinion and my overwhelming opinion since then is that from a clinical standpoint, if I had to create a differential diagnosis, my differential diagnosis in this case would be cocaine psychosis, cocaine psychosis, cocaine psychosis, cocaine psychosis, and then maybe something else, but I can't imagine what else it would

be.

Q. What were the indicia, if you will, of cocaine psychosis that you observed in the record as surrounding the murder of these two individuals?

A. What would be the addition?

Q. The indicia, the indications that Mr. Hicks was in the throes of cocaine psychosis when these two murders were committed.

A. I can -- I can open up the transcript and give you a couple specific examples --

Q. That would be helpful.

A. -- if you like.

The first I'll mention is the transcript from the Knoxville Police Department, and this transcript on its second page -- or on the first page, it says, "I went over to this guy's house that I knew and had some cocaine. So I bought me some." And then there's some information about the person he bought it from, and then "I used it and some after I went home and then that craving came, you know, to get some more dope. So what I did, I called the man and asked if he had some for me. He said okay. So I took the VCR we had at the home. So I went over there, and a little bit later I gave it to him, so he gave me some more. So I told him I would pay him back tomorrow. I realize I didn't have the money to get the video recorder because it wasn't mine, so I

got to thinking -- I said I've got to do something, you know, because the video recorder didn't belong to me. I knew there'd be a lot of bullshit going on with my wife, so what I did, I got to thinking well, since I'm supposed to have went to the ball game -- well, I didn't. Okay? So I called her" and he was calling his mother-in-law.

Those sorts of things, indicating sort of the person buys some cocaine, doesn't have any more money, is moving toward a cocaine binge regularly and routinely, hocks about anything they have that's valuable in order to get some more cocaine, and then once that's been done, frequently tries to figure out how to get some more money, it becomes more and more irrational.

So, "I need some more money. Maybe I should go rob my mother-in-law." That's entirely irrational, compared to robbing someone else who doesn't know you, who you would knock over the head and would never recognize you. That is crazy. But this man isn't crazy. This man does haven't a history of schizophrenia. He doesn't have a history of serious mental illness. That is an indication there of cocaine psychosis.

He states on the next page, "But getting back to where I was just going to leave," he said to the detective he was just going to leave the apartment, and then -- "So she was wondering about that cage and what the bird cage had in it

and blah, blah, blah. She turned around and I just grabbed her and started strangling her." That once again sounds like, you know, sort of the erratic sort of impulsive behavior of a person who's getting more and more sort of psychotic on a cocaine binge.

A little further on they talk about finding a gun. He said -- the interviewer said, "You could not find the gun?" And the defendant said, "Yeah, at first, then all of a sudden I realized that. I said, well, you know, Brandy knew I was the last one here, so, you know, it was like I was, 'No, I shouldn't do that to her,' you know." That sounds very much to me -- giving a law enforcement interview as opposed to a clinical interview -- of a person describing intrusive thoughts that are coming in that are bizarre and completely irrational sort of, you know, coming into a person's mind.

"And so, after I got the money, I said 'I'll leave and come back and clean up this mess.' So I called the man and I finally caught up with him." I think that -- "...finally caught up with him." In the interview with Shirley Lehmann (sic) later on, he talks about how he couldn't call the person, there was no answer on the phone, the phone was busy, he was pacing around the apartment, more and more edgy, irrational, and dashed out and got more cocaine and came back here and used cocaine right here in the same place. Despite having already gotten the money and gun and everything else

is -- is -- clearly the most likely clinical explanation is cocaine psychosis.

So, he went and got some more cocaine. "And then must have been around 12:30, something like that, I went on ahead and shot up the dope. I got -- I got a 50-cent piece and all of a sudden I got to thinking again" -- "I got to thinking again," just typical cocaine psychosis and shortly thereafter intrusive thoughts, "I started thinking again well, I'd better go ahead and do this because she's going to be the only" -- referring to Brandy, and so, you know, he committed the second murder.

Q. Well, is that evidence of rational thinking, to cover up a crime, or does it reflect something else in your clinical opinion?

A. All of it -- I mean, from -- from the trying to figure out how to unhock the VCR on is some of the most bizarre and irrational thought patterns that one can imagine, or at least that I can imagine, and indicates more and more paranoia and bizarre behavior and is quite indicative of cocaine psychosis.

Later, it says "It was in the living room, but I dragged it to the bedroom" -- which is Maxine's body. "...then I got to thinking I need to do something with it before someone discovered it, so I was going to cut her in half and put her in the freezer, and all of sudden I did and then I stopped."

I mean, that is crazy. That is not the actions of a person who is -- whatever. And then --

THE COURT: You used the term "crazy," Dr. Parran. Could you relate that to the opinions you've expressed about cocaine and psychosis?

THE WITNESS: I'm using the vernacular "crazy," that is, bizarre thoughts and actions of a person who is -- who is clinically most likely involved in a cocaine psychosis given a past history of no mental illness.

A. (Continuing) And then finally on the next page there talking about the sexual abuse of the girl: First, you know, I was thinking all weird. Thinking all weird." Here's a person, a day later even, describing his own thoughts of, you know, thinking all weird, and so those are the evidences in the police report.

And then it takes some time, but reading through the report from Ms. Leahy, there's what I consider to be just much more data from a trained clinician interviewing about these issues, asking followup questions about "What do you mean 'thinking all weird'? What kind of thoughts were you having?" -- and those sorts of things.

Q. Based on the information you were able to obtain from the record, your conversations with Mr. Hicks and any other materials that you were provided, do you have an opinion, to a reasonable degree of medical certainty, as to the duration

of the cocaine psychosis which you've just testified about?
A. The -- my best clinical judgment would be that the cocaine psychosis and -- that the cocaine psychosis certainly continued through the time that Mr. Hicks went home to his -- his and his wife's apartment. Probably until the time that he drove out of town and maybe until the time he actually went to sleep in Knoxville.
Q. Let me ask you this question --
THE COURT: When did it start?
Q. That was my next question, the onset. In your opinion, to a reasonable degree of medical certainty, what was the onset of this cocaine psychosis?
A. The onset was probably shortly after the second self-administration of cocaine; the cocaine that was used -- the cocaine that was bought with the VCR.
Q. Now, Dr. Parran, in your professional opinion, were the Court and the jury properly and accurately informed through the testimony of the witnesses who were presented at trial as to the nature and extent of Mr. Hicks' cocaine dependency and psychosis at the time he committed these acts?
A. No.
Q. And why is that?
A. It's clear from my reading of the transcript that the information that was provided about cocaine pharmacology was inaccurate during the trial; that the information given

regarding the timing of -- the difference between cocaine intoxication and the cocaine psychosis was not entirely but largely inaccurate, and that the information that was given about the signs and symptoms of cocaine psychosis were substantially inaccurate. The information given regarding the expected onset of cocaine psychosis, based upon the timing of the use of the drug, was inaccurate, as well as the expected duration of cocaine psychosis. That also was inaccurate. And, finally, the idea that cocaine psychosis was more likely to happen in a person who was a chronic, daily user of cocaine with day in and day out cocaine use, which is actually very rare for people to actually do that but even more rare for people who have cocaine psychosis, but that was entirely inaccurate.

Q. Dr. Parran, if you're able to do so, are you able to refer to portions of the record in which you feel that there were substantial inaccuracies or errors with respect to the information that was provided to the Court and the jury concerning Mr. Hicks' cocaine --

A. Sure.

Q. -- situation?

A. Sure. And I'll do it in whichever way is usually most appropriate in these settings. I can give the page and -- the page number and the line number.

Q. Are you able to pinpoint who the witness is?

A. If you want me to read the statement --
Q. If you could summarize perhaps what the statements are, but also if you could indicate which witness is providing this inaccurate information to the jury.
A. Okay. The primary information which was inaccurate was provided in the testimony of Nancy Schmidtgoessling, and her testimony started on Page 1175. The areas where the inaccuracies were most notable is on Page 1178 -- I'm sorry 1187, where they talk about the difference between snorting cocaine and using cocaine I.V. And Dr. Schmidtgoessling gave clearly wrong information from Line 22 on that page through Line 6 on Page 1188. The information -- should I read the information, or just --
Q. If you could summarize it.
A. Okay. Well, it basically said that that cocaine goes into the bloodstream faster if you snort it than if you use it I.V., which is wrong. She says that the intensity of the symptoms of the intoxication of cocaine are equal, whether you used an I.V. or snort it, which is clearly wrong. And she said that the reaction would be -- that the only difference between using cocaine nasally versus I.V. is that the reaction might be quicker nasally rather than I.V., and it is not the only difference and, in fact, that's wrong.
Then on Page 1191, starting at Line 11, they talked about the levels of intoxication from cocaine being similar to the

levels of alcohol, various degrees of intoxication. And the question -- or the response of the expert was that they were similar; that, you know, there were sort of a linear intoxication effect from cocaine similar to alcohol, which is -- which is not the case. Cocaine has much too short a half life to be able to look at levels of intoxication.

Then at the top of the next page on 1192, the question was would cocaine be the same curve of dysfunction? Can the effect and degree of one's ability to perform depend upon the amount that a person took in? -- meaning if you only took in a little cocaine now, it will have a little effect, and if you took a lot of cocaine, it will have a lot of effect. And the expert said "Yes," definitely demonstrating no evidence of the knowledge of the kindling phenomena that we talked about before where one has activated kindling with cocaine addiction. Even reasonably small amounts of the drug can precipitate in large behavior, rational changes.

Page 1193, the description of why people die from cocaine: "In fact, when people die of cocaine overdose, it is usually from a respiratory problem." Virtually no one dies of a cocaine overdose from a respiratory problem. It is a seizure, stroke or heart attack. It has little to do with the lung.

She then points out later on that page that this patient -- or this defendant was able to retain his orientation and

his goal directedness and, therefore, he was not significantly affected by cocaine when he was committing the crimes. As I described earlier, it is in the literature, and in the 1980s, in the literature now, when a person is involved in cocaine psychosis, they are oriented, they know who they are, and where they are, and when it is. They are oriented to person, time and place. They are nct delirious and they frequently follow through with impulsive actions, although they tend not to be able to follow through in a single plan of action over an extended period of time.

And then, finally, throughout this entire section, all of the statements were about the -- about whether he was intoxicated at the time, not whether there was the dysphoria and the paranoia and cocaine psychosis.

There's just a couple more here. On Page 1195, starting at line 18, the question is:

"Let's talk about that. This stuff reaches a peak in fifteen to twenty minutes."

And the response from the witness was...

"Yes, that is customarily thought to be the peak."

Well, that certainly is not when you're using I.V. cocaine. It is gone in ten.

The question then was...

"Then the person returns to normal later

rapidly?"

And the response was...

"Yes, usually sort of a crash, as they refer to it. It usually takes ten to fifteen minutes."

Actually, the crash is, after a binge, often a few hours after a binge, which tends to last proportional to the length of the binge.

"Question: The whole thing is less than half an hour?"

"Answer: Not if there is something mixed in, but, yes."

"Question: Doctor, did you actually" --

I'm sorry, the next page, 1196, pretty close to the end...

"Doctor, did you actually make an examination of the life background as part of your history to determine his work record, the way he dealt with his peers and so forth?"

"Yes, I did."

"Question: Did you see anything in there that indicated either cocaine usage or chronic usage of cocaine?"

And the answer on Page 1197 reads...

"I didn't see anything as far as chronic usage. He was regular to work, he was cooperative with his co-workers, he was a good employee and reliable."

All of that information, given a history of binging on several thousand dollars of cocaine a few years earlier, a couple thousand dollars use of cocaine six months earlier, and given the history of a person who went to work and participated normally in working during the day and wound up committing two murders and other things later during the night, is absolutely diagnostic of cocaine addiction and cocaine psychosis, and her statement is that is that it's no indication of chronic use. I think -- I think that's it.

Q. Dr. Parran, in your professional opinion, based on the information that was presented at trial and which you've just commented on, do you believe the jury was fairly and accurately apprised of the effects of cocaine on Mr. Hicks' conduct that night?

A. Absolutely not.

Q. Okay. For the reasons you've stated?

A. Yes.

Q. Now, Dr. Parran, this case took place in 1985; that's when the trial took place. What was the current state of medical knowledge of cocaine and cocaine psychosis at that time?

A. Well, that's a very good question. Certainly we know more about cocaine now than we knew in 1985 and 1986, but that's because we've experienced our current cocaine epidemic which started honestly in probably 1976. But we've

experienced it for another decade since then. But in 1985 and '86 -- and I think the trial actually took place in February of '86 -- cocaine addiction was well-known. It was in the DSM-III, and then subsequently published a little later in 1986, the DSM-III-R, and now in 1995 the DSM-IV, cocaine psychosis and stimulant psychosis. Amphetamine psychosis has been described in the literature since the 1950s. In fact, there are a few descriptions later in the Western European literature, the German literature from the 1930s, of paranoid ideation and bizarre behavior from cocaine.

But what would be most available to practitioners in our community in Ohio in 1985 are several articles from well-respected psychiatric journals and widely-read psychiatric journals from the mid- to late-'70s right up until 1986, and certainly since. They talk about cocaine psychosis, paranoia associated with cocaine, these long last -- longer lasting effects of cocaine than just the mere intoxication.

Q. Dr. Parran, let me stop you there and ask if I might hand you an exhibit, Plaintiff's Exhibit 17.

Could you identify that exhibit for us, please?

A. Yes, it's a face sheet or a Xeroxed copy of a face sheet of a list of articles in the medical literature, that I wrote down the initial or the earliest one being in 1931, the last

one being in 1986, early 1986 -- I think published in February of 1986 -- basically listing articles in the medical literature about cocaine dependence, cocaine addiction, including references and descriptions of cocaine paranoia, cocaine psychosis.

Q. So what Exhibit 17 is, is a compendium or a list of the articles?

A. The first page is a list and attached are the actual articles.

Q. And these are examples of the type of materials that were available to practitioners by February of 1986?

A. Absolutely, yes.

Q. Is there anything about which you have testified this morning relating to cocaine, cocaine psychosis, the kindling effect, the binging, the psychosis, the paranoia, the duration of cocaine psychosis which would not have been available to practitioners in this field in 1985 and 1986?

A. In general, no. There is one -- I did cite one piece -- one statistic where it's thought that 50 to 70 percent of people who -- who use cocaine in a binge-crash pattern experience clinically significant paranoid ideation, with better than half of them actually arming themselves with weapons during cocaine binges, and that was published after 1986.

But the description of the kindling phenomenon with

cocaine psychosis, as well as cocaine seizures, the description of the typical binge-crash pattern and the description of cocaine psychosis itself and cocaine paranoia coming on after the intoxication of cocaine and lasting well beyond the intoxication of cocaine are all very well documented in the medical literature in 1985, '86 and before.

Q. And to your knowledge, Dr. Parran, was that information and examples of that literature available to practitioners in that field of addiction in Cincinnati, Ohio in 1985 and 1986?

A. Oh, absolutely. One of the articles is from the American Journal of Psychiatry, the most widely distributed, widely read journal, psychiatric journal in the country, and that is from March of 1975 and its titled is "Cocaine Psychosis: A Continuum Model."

There is an article from 1976 in the same journal, the American Journal of Psychiatry, and the title is "Cocaine, Kindling, and Psychosis." That was a decade before these events.

And then I have a few here, one in 1986 "Neuroleptic Reduction of Cocaine-Induced Paranoia" in the Journal of psychopharmacology published in February of 1986, the same month of the trial. Even the Psychiatric Annals in 1984 -- the psychiatric annals are very widely distributed -- have articles describing -- describing the same thing.

MR. MEZIBOV: Your Honor, if I may have one minute,

that may be it.

(Messrs. Mezibov and Lazarow conferred privately.)

Q. Two final questions, Doctor. First, with respect to this information and the availability of these materials as an extension of that question, were there, and to your knowledge, practitioners in the field which you study and about which these articles have been written who were available in Cincinnati to have this information at their disposal?

A. Well, certainly there were in the early 1980s. The Cincinnati V. A. has a big Addiction Medicine Treatment Program that was active then. They had a specific drug treatment branch, as well as a separate alcohol treatment branch. They treated them separately then. We're now treating them together with a psychiatrist as well as internists on their staff. In fact, the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse, two branches of NIH in 1980 developed a career teacher's program where they supported individuals of medical schools to acquire more education and then teach about addiction and the pharmacology of addictive drugs. And Don Nelson, who is a clinical pharmacologist at the University of Cincinnati, was a career teacher with NIAAA and NIDA from 1981, and was teaching a pharmacology course at the University of Cincinnati Medical School on drugs of abuse in

the '80s and is still there now.

Q. Dr. Parran, you also mentioned there was a study that evaluated or reported on the violence associated with cocaine psychosis, people being armed and the like. What is the correlation between cocaine psychosis and violent behavior?

A. The study that was reported, they studied a couple of hundred people who used cocaine in a binge, binge-crash kind of pattern, either smoking it or using it I.V. Seventy percent reported clinically significant paranoid ideation happening around the time of cocaine binges. The -- 50 percent of those who had paranoid ideation reported that the paranoid ideation lasted all the way through to the time of the crash, so it lasted for a few to several hours after the cessation of the cocaine use. Better than half of people with paranoid ideation reported that they had intermittently armed themselves during a cocaine binge with various weapons. And of that 50 percent who had armed themselves, a quarter reported having actually been violent. None reported actually ever having killed someone, but a quarter reported having been violent, including jumping out of windows because they were sure the police were coming through the door; beating up a significant other because -- thinking they were sending messages about the person using cocaine to law enforcement; misperceiving external stimuli and then reacting in a violent, arming way.

If you remember, norepinepherine adrenaline is the hormone which produces our fight or flight response. People, when they're overstimulated with norepinepherine, tend to get more and more paranoid, have more and more tough time focusing on something and tend to be hyper-reflexic, and really sort of armed. It's -- it's a hormone which -- which has tremendous survival benefits for humans; but when overstimulated with it, people can be very violent.

Q. The facts that you found in the record in Mr. Hicks' case, they're consistent with the findings of these studies you've just mentioned with respect to violence?

A. Yes.

MR. MEZIBOV: That's all the questions I have of this witness. Thank you, Doctor.

THE COURT: Doctor, in your history that you accumulated on Mr. Hicks, was there a history of seizures?

THE WITNESS: No, there was no history in his case of cocaine-associated seizures and that sort of kindling phenomenon. Just a kindling phenomenon in terms of the paranoid thoughts as such.

THE COURT: Can an addict that has become an intermittent binge-type pattern individual, can that addict reasonably be expected to overcome the addiction?

THE WITNESS: I couldn't give you worthwhile information in 1985 because the epidemic was too early at

that point. But at this point, I think we have some pretty good information, and the information that we have now is that if you take a thousand people with cocaine addiction, intermittent binging, whether they're smoking it or using it I.V., and you follow them up over 15 years or so, at the end of 15 years, better than a third of them will be sober and in stable recovery. Of the ones that survive -- because there is a highly fatal condition here -- that a third will be sober, in stable recovery, about another third will have switched to a different pattern of drug use, and that's honestly what we're seeing in Ohio now: People are switching to heroin since cocaine has sort of a short life; people are switching to mixing cocaine with heroin. They get jazzed up on the first use of cocaine, feel very -- euphoria. And when the dysphoria of the cocaine should be kicking in, that is when the sort of euphoric period, the mellow high of the heroin kicks in. And instead of going on a full-blown binge, a person tends to use cocaine and heroin together twice a day.

So, we've seen, sadly, about a third of our addicted patients, who normally were bingers on cocaine, just switch pharmacologically to a different approach but still be out of control with chemical dependence.

And, finally, another third are either incarcerated or dead.

THE COURT: So, it's reasonable to believe that approximately a third could be sober?

THE WITNESS: If -- if people escape either death or jail, the statistics are that 50 percent of the people, whether they have alcoholism or cocaine dependence, over time will eventually get sober and stay sober for outstanding periods of time.

THE COURT: Does the snorting of cocaine have any detrimental effect on those membranes and so forth? Is that permanent?

THE WITNESS: That can be permanent. It's probably not the cocaine itself that damages the nasal membrane, but what happens is when a person snorts cocaine, when the norepinepherine is released, there's spasm of the smooth muscle and the blood vessels that go in the nose, so people stop absorbing it. The nasal septum is made of cartilage and cartilage doesn't have its own blood supply. It depends on blood vessels to passively supply oxygen to the cartilage. And so, cartilage is exquisitely sensitive to not enough blood supply, and so what happens is actually the cartilage in the septum dies and deteriorates and falls out. To cite a famous example, Linda Ronstadt had cocaine addiction and was afraid of needles and didn't know how to turn it into freebase, so she just snorted and snorted and lost her nasal septum, went into treatment and had to have a nasal septum

replaced several years later by a plastic surgeon so she could sing again.

THE COURT: Did you conduct any physical examination of Mr. Hicks?

THE WITNESS: No.

THE COURT: Wouldn't that be medically prudent to help you make your opinion here today?

THE WITNESS: It may have been, although it was ten years after the fact.

THE COURT: Well -- well, I prefaced my question: Is it permanent --

THE WITNESS: The physical --

THE COURT: -- and you agreed.

THE WITNESS: The permanent signs I'd look at, that if I had thought of that, would honestly be from track marks, from I.V. marks.

THE COURT: You didn't see the I.V. track marks?

THE WITNESS: No.

THE COURT: They would still exist?

THE WITNESS: Track marks would probably exist, although the disclaimer that I would give you is that track marks in people who are opiate dependent tend to be much more chronic and long lasting, because people tend to use opiates in a chronic pattern. People tend to do intermittent binging on cocaine. They tend not to use the same vein, and so the

track marks tend to be much less permanent scars with cocaine use.

THE COURT: Did you examine, in reaching your opinion, any criminal history of Mr. Hicks?

THE WITNESS: Very superficially. I read one of the background psychological reports that talked about his history of domestic violence in the past while intoxicated. I didn't read that extremely carefully.

THE COURT: You don't know of any specific crime or criminal experiences with the law other than domestic violence?

THE WITNESS: At least based on my memory right now it was a domestic violence incident and a court-mandated outpatient counseling program in '82, I think.

THE COURT: Any other history which was not significant in your opinion?

THE WITNESS: Well, when I interviewed him myself and when I quickly looked through the past psychological record, I was looking for evidence of previous psychotic behavior, behavior that would indicate any mental illness or the behavior that indicated extreme violence, and all I saw was the domestic violence.

THE COURT: Thank you, Doctor. We'll recess until 1:15. 1:15. Thank you, Doctor.

THE WITNESS: You're welcome.

THE CLERK: All rise.

(At which time, the luncheon recess was taken.)

* * *

AFTERNOON SESSION (1:31 p.m.)

THE COURT: Is the petitioner ready to proceed?

MR. MEZIBOV: We are, Your Honor.

THE COURT: Respondent ready to proceed?

MR. WILLE: Yes, Your Honor.

THE COURT: Doctor, I believe you're on the stand. Proceed, Mr. Wille.

MR. WILLE: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. WILLE:

Q. Doctor Parran, have you ever testified at trial in a capital case?

A. No, sir.

Q. Have you ever testified in a criminal case involving cocaine as an issue?

A. No.

Q. Are you familiar with the factors set forth in Ohio law as to mitigation with respect to a capital offense?

A. No, I'm not.

Q. Now, you are not a psychologist or a psychiatrist; is that correct?

A. That is correct.

Q. Now, are you aware that Dr. Schmidtgoessling rendered an opinion in conjunction with this case that Mr. Hicks at one point had been feigning the symptoms of mental illness?

You're aware of her opinion in that regard?
A. Yes.
Q. Now, I take it -- or would you consider yourself to be competent, qualified to render an opinion as to the validity of her opinion in the latter regard?
A. I can certainly give you my opinion about that as an internist and a physician.
Q. Would you consider yourself to be an expert with respect to -- I'll withdraw that.
Would you offer an expert opinion as to the validity of her expert opinion?
A. I would not offer it regarding her opinion of his diagnosis of malingering or feigned mental illness.
Q. And that's what my question was directed to --
A. Okay.
Q. -- if I was not clear on that.
Now, Dr. Parran, would you think that you are qualified to render an opinion as to whether a person is suffering from a mental disease or defect?
A. I'm certainly qualified to render an opinion, but as a non-psychiatrist, I would probably not be considered qualified to render an expert opinion.
Q. Now, Dr. Parran, am I correct you did speak with Mr. Hicks?
A. Yes, I did.

Q. And you mentioned in direct testimony that you were, I guess, I don't know how you put it, but you were looking forward to the opportunity to speak with Mr. Hicks in the sense of the experience of doing so?
A. No, I wouldn't -- I wouldn't -- I wouldn't say that. I did think that it was important for me to have a chance to talk to Mr. Hicks once I had looked through the materials that had been forwarded to me and was -- and was at the place of beginning to form an opinion about cocaine psychosis.
Q. Would it be fair to say that your experience is somewhat limited in talking with persons who have been convicted of serious felonies?
A. Yes.
Q. And I take it -- it may seem to be an obvious question, but I take it you've never interviewed before someone who had been convicted of murder and sentenced to death?
A. I have interviewed people who been convicted of murder in the past, but no one who has been sentenced to death.
Q. Now, Dr. Parran, in forming your opinion with respect to Mr. Hicks, I take it that you gave weight to what he told you during the interview?
A. Yes.
Q. And now, Dr. Parran, in normally -- in normally dealing with persons with cocaine psychosis, do you on occasion rely on such things as, say, urinalysis tests or blood tests?

A. Yes; not -- not as it relates to cocaine psychosis, but as it relates to documentation of cocaïne use.
Q. Now, Dr. Parran, you've testified that you assisted with the training of interns with respect to handling persons in emergency situations. Is that a fair statement?
A. Yes.
Q. And I take it that in that circumstance you would be dealing with a situation where the person that may be suffering from a cocaine psychosis is right before you at the critical time, if you know what I mean?
A. Yes.
Q. So, I take it then that you would consider that to be a very important thing to consider, namely the opportunity to actually observe the person under -- appear or under the possibility -- strike that -- actually observe the person in the highly agitated state which would be consistent with cocaine psychosis?
A. Certainly the people who observe patients the most when patients are actively involved in a state of cocaine psychosis are people who work in Emergency Rooms, ambulances, intake offices, those sorts of things.
Q. Would you say you're one of those persons?
A. I certainly have done a lot of consultations in Emergency Rooms, yes.
Q. Have you -- in your function as a consultant, would you

say that -- I take it you have actually seen people that appear to be under the symptoms of a cocaine psychosis?

A. Yes.

Q. And in this particular case, however, you've never seen Mr. Hicks under --

A. No.

Q. -- apparent influence of a cocaine psychosis?

A. No.

Q. Now, Dr. Parran, are you aware or have you reviewed Dr. Hawgood's report with respect to Mr. Hicks?

A. I'm sure that I have because I'm -- I think it was in the materials that I looked at, yes.

Q. If I were to represent to you that during an interview with Dr. Hawgood Mr. Hicks admitted that at one point he feigned the symptoms of mental illness, that would -- that would be consistent with your recollection of Dr. Hawgood's report?

A. Yes, as well as Dr. Schmidtgoessling's opinion.

Q. Exactly. And would it be -- or do you recall that in the course of her report, Dr. Hawgood indicated that Mr. Hicks stated that he had been advised by certain jailhouse lawyers to feign these symptoms of mental illness because it might be beneficial to his case? That would be consistent with your recollection as to her --

A. Yes, I think it was multiple personality disorder, or

something like that.
Q. If I were to tell you that Dr. Hawgood testified in a deposition in this case that in fact Mr. Hicks had indicated to her that "Yes, I -- I did feign some mental illness because I was advised by jailhouse lawyers," that would be consistent with your recollection of --
A. Uh-huh.
Q. -- your review of that deposition?
A. Yes.
Q. Now, would it be fair to say, Dr. Parran, that in that circumstance Mr. Hicks appeared to be willing to tell Dr. Hawgood a falsehood -- strike that.
Would it appear, based on Dr. Hawgood's statements, that Mr. Hicks had occasion to lie because he thought it would help his case?
A. Yes.
Q. Now, have you considered the possibility that when Mr. Hicks described his cocaine use to you, that perhaps he was entertaining the same intent to lie?
A. Yes; I must -- that's certainly a possibility that I've thought about, and thought about at the time I interviewed him. I must say that the majority of my opinion is based upon the data in the interview with the detectives in Knoxville and based upon information and, secondarily, based on information in the interview with Ms. Leahy, I think in

September of '85, both of which, at least to my review, appear to have taken place prior to much of the other behavior that Mr. Hicks demonstrated with other examiners.

Q. Would you be -- are you aware that Mr. Hicks demonstrated some aberrant and bizarre behavior to Mrs. Leahy?

A. The second -- the second day, the second interview day, yes.

Q. And are you also aware that after Mrs. Leahy's interview with Mr. Hicks, that Mr. Hicks expressed similar -- or showed similar behavior in his interview with Dr. Schmidtgoessling?

A. Yes. My impression was that his initial interview with Ms. Leahy was an extended interview in which he appeared to be giving consistent information which anticipated to be reasonably backed up with interviews with other family members and the second interview was much more bizarre. And from there on, the interviews were -- were difficult.

Q. Now, Dr. Parran, you have examined, I take it, much of the information that Mrs. Leahy gathered?

A. Yes, I think I read the report entirely.

Q. Are you aware or do you recall that at one point Mr. Hicks himself stated in the course of Dr. Schmidtgoessling's investigation as to his sanity that he, in fact, did not abuse cocaine or alcohol?

A. Yes.

Q. And would it be fair to say, Dr. Parran, that some of the

information cited by Mr. Hicks in support of his -- his allegation or assertion of cocaine psychosis was developed in State post-conviction proceedings? Would that be a fair recollection or statement as to your recollection of the record?

A. I have a problem with Mr. Hicks -- with the beginning part of your statement, because it was not my impression from reading any of the materials that Mr. Hicks claimed a cocaine psychosis.

Q. Are you familiar with the affidavit of Dr. Baum?

A. I'm familiar with Dr. Baum's affidavit, which was obtained in 1990.

Q. Yes. And, therefore, it was obtained -- you would have no reason to doubt it was obtained in conjunction with Mr. Hicks' post-conviction action; correct?

A. My understanding is that Dr. Baum's opinions were formed in 19 -- late 1989-90, after the conviction.

Q. And isn't it true that Dr. Baum relied on information in forming his opinion that was brought out following Mr. Hicks' conviction and during his post-conviction action?

A. Yes, with -- interviews with Mr. Hicks and others.

Q. So, it is then fair to say that at least in part your diagnosis is based on information which was developed subsequent to Mr. Hicks' conviction?

A. Certainly the information in Dr. Baum's evaluation of

chemical dependency regarding Mr. Hicks was a more thorough evaluation and had more information than was available from the earlier charts, yes.

Q. Well, correct my recollection if I'm wrong, but do you recall Dr. Baum referring to instances of hallucinations and other aberrant behavior by Mr. Hicks?

A. Yes.

Q. And isn't it fair to say that Dr. Baum was relying on, to some extent, on Mr. Hicks' assertions of hallucinations following his apprehension?

A. Yes.

Q. Dr. Parran, you testified that Mr. Hicks' actions on the night of the murders were consistent with the symptoms of cocaine psychosis. You would agree, I'm sure, that there are persons who commit violent acts that are not necessarily operating under the influence of a cocaine psychosis?

A. Yes.

Q. Now, you stated on direct -- again, tell me if I'm wrong -- 50 to 70 percent of persons under the influence of cocaine psychosis suffer paranoid ideation?

A. That's not quite, but it's --

Q. Pretty fair summary?

A. Actually, 70 percent of people who intermittently binge on cocaine describe clinically significant paranoid ideation.

Q. Could you be more specific as to you say "clinically

significant of paranoid ideation?" Are you saying 50 to 70 or 60, or whatever, persons would exhibit violent behavior comparable to Mr. Hicks' behavior?

A. Well, I think my statement was that most clinically rigorous data we have right now about cocaine binging and paranoid ideation is that 70 percent of people who binge on cocaine have paranoid ideation. Of those 70 percent who have paranoid ideation, more than half report repetitively having armed themselves with a weapon of some sort because of the paranoid ideation while binging on cocaine. And that of that half who have armed themselves, half of them, a quarter of the overall 70 percent, report having acted violently toward themselves or others during the cocaine binge subsequent to the paranoid ideation. That's what I said.

Q. If I understand this correctly then, you have started with 50, 60, 70 percent and you've broken that down to where you're saying now that 25 -- actually 25 percent of these persons exhibit or actually exhibited some form of violent behavior?

A. Might be a little less than that. Probably in the range of 18 to 20 percent.

Q. Now, I don't know if you have the statistics on this or not, Dr. Parran, but of that 25 percent or less --

A. Yes.

Q. -- of the people who do violent behavior --

A. Yes.
Q. -- how many of those people commit two murders?
A. I honestly don't think anyone has that data. I tried to find credible research data on that and was not able to. What I -- what I can say is that -- is that the leading cause of death from cocaine addiction is violence by several times greater than heart attacks, strokes, seizures, as we discussed before. But I can't -- that information honestly doesn't exist.

THE COURT: Excuse me. Before you leave that point, when you say "violence," do you mean self-destruction?

THE WITNESS: Suicide or homicide.

THE COURT: So that --

THE WITNESS: And at times both.

THE COURT: And how -- what is the percentage of suicides, homicides?

THE WITNESS: I tried to find that as well and was not able to.

THE COURT: Thank you.

A. (Continuing) I can give a little bit of information, but it isn't specific to cocaine. The -- the information I was able to get, or the information that I heard when I was testifying at the American Bar Association's Special Committee on Drug Crisis and Special Committee on Violent

Q. Now, by doing this, I don't mean to suggest any relative importance; I'm just kind of breaking it down logically. And Part 2 would be things that Mr. Hicks' family members or contacts or other things from his social history from which you were able to make some determinations as to his possible frequency of cocaine use?

A. Yes.

Q. And the third aspect would be your analysis of Mr. Hicks' behavior on the night of the offenses?

A. That certainly is part of it. Certainly a big part is the actual interviews by others, the detectives and -- especially the detectives and Ms. Leahy of Mr. Hicks.

Q. I guess I'm including that.

A. Lump them in one or the other.

Q. Exactly. Now, in terms of the third component, wouldn't you agree that an important aspect of your diagnosis is your opinion as to whether Mr. Hicks' behavior was irrational or bizarre?

A. Yes.

Q. And would you agree that perhaps reasonable minds could differ, reasonable expert minds could differ, as to whether Mr. Hicks' behavior manifested irrationality or bizarre character?

A. Yes, I think that reasonable minds could differ on the amount of -- on the amount of weight they lend to the -- to

the irrationality or the bizarreness of the behavior, although it -- from what I remember from reading through the other people's opinions, pretty much everyone's opinion, especially Dr. Schmidtgoessling's opinion, was that this was irrational, erratic, uncharacteristic behavior for -- for him.

Q. You did review Dr. Reardon's transcript, I take it?

A. Yeah, I just reviewed that in the last couple days.

Q. And it's fair to say that Dr. Reardon -- or Dr. Reardon found some of Mr. Hicks' behavior to be not irrational or erratic in his opinion?

A. Yeah, I think that he found some of the behavior irrational and erratic and some of it not so much.

Q. Now, you mentioned before, Dr. Parran, you used the word "weight" in terms of -- in relationship to the opinion about whether someone's acting irrationally or bizarrely. Do you have any knowledge or information with respect to a person's behavior in relationship to the mitigating factors that are possible under Ohio law with respect to a capital case?

A. I honestly am not aware. I am -- I know nothing about mitigating factors in Ohio law regarding capital cases.

Q. Would it be fair to say that in determining the rationality or bizarreness of a person's behavior in relationship to the issue of whether there's a mitigating circumstance which is permissible under Ohio law, that a

person who had experience, professional experience, in the latter regard, in the regard of presenting evidence or in assisting in these types of issues, that their opinion might have more validity than yours?

MR. MEZIBOV: Objection.

THE COURT: He may answer. If you understand the question.

Q. I admit it is a pretty tough question.

A. I think I do. My opinion was requested about cocaine pharmacology and about the clinical and to give a clinical opinion about what was going on with Mr. Hicks on that day, and that is what my opinion is about. I think that the weight of my opinion is -- my personal feeling about this is that my personal opinion should be based on my own knowledge of cocaine pharmacology, my knowledge of cocaine dependence, my knowledge of working with patients with cocaine dependence, cocaine psychosis, and my ability to look at an indication and interpret the signs and symptoms that I see in the case in terms of my background.

Q. Now, Dr. Parran, you're aware, of course, that your opinion is being offered with respect to an allegation of ineffective assistance of counsel?

A. I'm sure that I've heard that. I'm not sure I understand what that means.

Q. I see. Would it be fair to say -- withdraw that.

And you're aware, Dr. Parran, that the allegation of ineffective assistance of counsel involved the attorneys' alleged negligence in failing to consult an expert such as yourself?

MR. MEZIBOV: Objection.

MR. WILLE: Your Honor, may I state why I'm going into this? Your Honor, the State's position is that this hearing, of course, is not really at the first instance about Mr. Hicks' cocaine psychosis or state of mind. In the first instance, it's about his attorneys' reasonableness in deciding whether to pursue this line of defense in either trial or mitigation; therefore, any evidence or any testimony relative to whether this information would have been in fact viewed by the attorneys is relevant to mitigation in Ohio, is relevant and should be explored.

THE COURT: Thank you, Mr. Wille. Denied.

MR. WILLE: Thank you, Your Honor.

Q. Now, you mentioned, Dr. Parran, that you relied in part on Mr. Hicks' statement to the police?

THE COURT: I'm sorry. Did he answer the last question?

THE WITNESS: No, I didn't.

Q. I'm sorry?

A. I don't know what it was.

Q. I didn't give you the opportunity to answer the question.

MR. WILLE: Thank you, Your Honor.

THE COURT: I was interested in it.

MR. WILLE: I'm glad you were, Your Honor. I apologize. I lost my train. Could you read it back to me? I don't remember.

Q. Well, are you aware, Dr. Parran, that this case involves the allegation that counsel, Mr. Hicks' counsel, was ineffective for failing to explore or hire an expert such as yourself?

A. I'm aware that that's -- that that's one of the things they asked me about early on, which was to form an opinion about the quality of the testimony as it related to cocaine pharmacology of cocaine psychosis, yes.

Q. You testified on direct that you felt that the jury was given inadequate or inaccurate information --

A. Yes.

Q. -- on this issue, but you would offer no opinion or you do not claim any expertise with respect to whether that inaccuracy in any way is related to a case in mitigation in Ohio.

A. Since I don't know what any criteria are for mitigation, I'd be on pretty thin ice on giving an opinion on it.

Q. Now, Dr. Parran, is it fair to say that you relied in forming your diagnosis on Mr. Hicks' statement to the police; is that a fair statement?

A. Yes, I certainly weighed that very carefully.
Q. Now, Dr. Parran, would you consider Mr. Hicks' statement to the effect that he left the door open of the apartment so he could return later without being detected, would that be an indication of bizarre or irrational behavior in your opinion?
A. Returning to the apartment struck me as fairly irrational behavior, having already taken what he was taking to go get more cocaine. But, leaving the door open and/or taking the key, I don't remember which, or both --
Q. Well, let me clarify that. Do you recall Mr. Hicks saying he had left the door open when he left so when he came back he could get in without, I guess, without being detected or being seen?
A. Uh-huh.
Q. Now --

MR. MEZIBOV: There is an objection, unless Mr. Wille can go to the record and be precise, because he's apparently now speculating as to what may or may not be in the record and asking a witness to answer with respect to what may be illusory statements.

THE COURT: This is cross-examination, testing the credibility of the opinion of this witness. Denied. And, Doctor, if it's something you didn't consider, just tell us that. You don't have to -- if you can't recall it or you

didn't consider it, just tell us that and we'll go on.
A. It's something that I noticed when reading the statement. It's not something that struck me one way or the other in terms of whether this individual was paranoid and potentially involved in cocaine psychosis. The reason I say that is because reading -- reading that statement one way -- and I certainly can find it in here, if I need to --
(Witness reviewing the transcript.)
A. Hmmm. Well, I can't find it right at the moment. But looking at that statement one way, it lended (sic) support for an idea of being paranoid about being seen and being paranoid about or being suspicious and paranoid in behaviors.
Q. Dr. Parran, would you think that a person who's committing a crime may be paranoid about being apprehended or detected even though they're not under the influence of cocaine?
A. Yeah, I think there is certainly a difference between a person being worried or suspicious and being paranoid.
Q. Well, then let me rephrase my question. You would agree or you would concede that a person that was committing a crime would show some worry and suspicion --
A. Yes.
Q. -- show worry and suspicion about being detected?
A. Certainly.

Q. Now, do you recall Mr. Hicks' statement to the effect that he brought the tape from the car when he went up to the apartment the second time and murdered Brandy?
A. Yes.
Q. You recall that statement?
A. Yes.
Q. Now, in your opinion is that indicative of irrational or bizarre behavior?
A. No.
Q. Now, Dr. Parran, do you recall a deposition taken by my office with respect to this case?
A. (Nods head affirmatively.)
Q. And you were asked the question, I believe, that did you find anything inconsistent in these facts with your diagnosis of cocaine psychosis?
A. Yes.
Q. And you recall answers that you felt there was nothing inconsistent with a diagnosis of cocaine psychosis?
A. Yes.
Q. Wouldn't it be fair to say your testimony that you've just made that Mr. Hicks' taking the tape with him to go up to the apartment before he murdered Brandy, if viewed as indications of rational and thoughtful behavior, indeed would be inconsistent with your diagnosis that he was under the influence of a cocaine psychosis?

A. By not characterizing it as irrational, I certainly wouldn't characterize it as rational or thoughtful behavior. Secondly, it is not -- I would disagree. As I -- as I tried to explain this morning, and as I think is a widely held misconception, perhaps, regarding this case, but certainly in many areas, a person who has a cocaine psychosis is moving from the paranoia, from mild paranoia of cocaine use to more severe paranoia, and what we would call cocaine psychosis is a person who is not. And clinically there's no evidence that these people behave like a completely disorganized, paranoid, schizophrenic, delirious individual, that some of their actions and behaviors appear to be and are extremely erratic, impulsive with intrusive thoughts, paranoid ideations oftentimes with auditory hallucination. Oftentimes their behaviors are those of a person who is much less disorganized than that, although certainly much more disorganized than they would normally be in life. And these sort of "waxes and wanings" of this phenomenon during the time of the cocaine psychosis is what makes the individual so unpredictable and what makes their -- their actions so unpredictable.

Q. Would it be fair to say, Dr. Parran, that in your opinion during a cocaine psychosis there are times when a person may act rationally and with intent and premeditation with respect to a particular act?

A. I have to make the disclaimer that not being trained in

forensic psychiatry I'm not in a position to respond to exactly the terms that you used. But what I can say is that when a person is involved in a paranoid, severely paranoid or psychotic episode around the use of cocaine, some of their actions are less disorganized and more purposeful than others. But what's characteristic of the overall phenomenon, that is that the person tends to intermittently lose track of their -- of their purpose and -- and go off on various tangents and side behaviors that are fairly indicative of this very unstable sort of psychiatric moment that the patient is in, and that is -- is what actually the cases that you're citing indicate to me.

Q. Let me go back to what you said at the very beginning. You're saying that perhaps you would not feel qualified in terms of rendering an opinion as to the possibilities of -- from a psychological standpoint of a person acting rationally and with premeditation and specific intent during a cocaine psychosis?

A. I am not familiar or trained with issues of premeditations, et cetera. I can, as a clinician, look at patterns of behavior, rationality and irrationality, levels of organization and disorganization of thought and come up with clinical opinions about that.

Q. Doctor, may I refer to your chart? During these times of cocaine psychosis, would it be possible for a person to act

rationally and logically and with premeditation during the course of this period?

A. The most consistent actions that people clin -- clinically that people pursue during a cocaine binge is seeking more cocaine. And as they become -- as they progress in the binge and as they self-administer the drug a second or a third or fourth or sometimes many more times than that, the amount of paranoia in their behavior and the irrationality of their behaviors tend to become intensified.

Q. Would it be possible, however, Doctor, for Mr. Hicks, assuming that he was operating under a cocaine psychosis during these periods, to perform purposeful, intentful (sic) and seemingly premed -- acts of premeditation, even though in your clinical diagnosis he was suffering under a cocaine psychosis?

A. Certainly people are able to perform purposeful actions; I certainly could agree with that. There were purposeful actions in this case. They tended not to be extended, purposeful actions. They tended to be pretty short lived and then using more cocaine. But certainly people can do purposeful actions when they're involved in cocaine psychosis.

MR. WILLE: One moment, Your Honor.

(Mr. Wille and his colleagues conferred privately.)

MR. WILLE: Just a couple more brief questions.

Q. Dr. Parran, on direct you referenced a Dr. Nelson?
A. Don Nelson, yes.
Q. Could you tell us again who Don Nelson is?
A. Don is a clinical pharmacologist on the staff of the University of Cincinnati School of Medicine who has received a -- who received a training award and was trained in chemical dependence and early -- pharmacology -- in the early 1980s and was teaching in this area, teaching about chemical dependence, about pharmacology of mood-altering substances in this area. He -- and probably knows many of the people in this area who may have been more clinical experts as opposed to pharmacology experts.
Q. In reviewing the materials in this case, did you recall seeing a letter by Mr. Hicks' defense counsel to Mr. Nelson?
A. No, I don't.
Q. Were you aware -- and you would have no knowledge whether they in fact did or did not in fact try to contact Mr. Nelson?
A. No, I do not. But the reason why Dr. Nelson's name came up is because he is one person who I know is from Cincinnati, lives in the area, I'm certain was practicing in this area in the mid-1980s and had a good deal of experience with amphetamine psychosis and cocaine psychosis as a clinical pharmacologist.
MR. WILLE: Thank you.

REDIRECT EXAMINATION

BY MR. MEZIBOV:

Q. Dr. Parran, I just have a couple followup questions to Mr. Wille's.

The first, Mr. Wille asked you some questions concerning your knowledge that the record contains references to feigned mental illness by Mr. Hicks. You remember those questions?

A. Yes.

Q. And my question is, what effect does the fact that Mr. Hicks may have feigned mental illness have on the opinions you've offered regarding cocaine psychosis and its impact on Mr. Hicks and the actions which he committed that night?

A. I can't give a clinical opinion about whether there was feigned mental illness or not. I certainly can give, because I'm not a psychiatrist or psychologist, but I can certainly give my opinion that the people who did the examining seem to be very appropriate in that decision. Mr. Hicks' history of attempting to feign mental illness, and not very well, didn't really have any negative impact on my opinion; that the record is very clearly supportive of cocaine psychosis.

Q. So, regardless of the fact that Mr. Hicks may or may not have been feigning mental illness with his attorneys or any of the people who interviewed him after the fact, your opinions regarding cocaine psychosis and its impact in

connection with the acts remains the same?
A. Yes, absolutely.
Q. Now, Mr. Wille also mentioned a Dr. Reardon. Is that correct?
A. Yes.
Q. And is it accurate that we provided you a copy of Dr. Reardon's deposition --
A. Yes.
Q. -- that we took just a week or so ago?
A. Yes. I actually read it yesterday, on Tuesday, because I just got back from a week teaching overseas on Monday.
Q. I'm going to ask you -- I don't know if you have the deposition in front of you.
A. I left them in the car.
Q. Let me do this.
MR. MEZIBOV: If I might approach, Your Honor.
(Mr. Mezibov handing the witness the document.)
Q. Dr. Parran, what I've done is placed in front of you Dr. Reardon's deposition and I have highlighted excerpts -- an excerpt from Page 38 in yellow.
A. Yes.
Q. Which lines does that run from?
A. Page 38, line 12 through 20.
Q. I would ask you to read that passage to us, first.
A. "In my opinion, the description that Mr. Hicks provided

is not indicative of someone who was in such a state of cocaine psychosis that they were unable to reason, that they were unable to plan, that they were unable to form intent, that they were unable to calculate a course of conduct, delay initiating parts of that course of conduct, plan ahead as opposed to the kind of grossly disorganized, erratic, inconsistent, savage kind of behavior that I have seen in a number of either cocaine psychosis or schizophrenic psychosis cases."

Q. Now, my first question with regard to that passage that you read is, as an individual with the qualifications you have provided to us, do you agree with that comment or that passage by Dr. Reardon?

A. I do not agree with the passage or the comment.

Q. Why not?

A. Because I think that this comment, once again, speaks to the misconception that people with clinically significant, meaningful cocaine -- degrees of cocaine psychosis that are heavily influencing their behavior need to look like "grossly disorganized, erratic, inconsistent, savage kind of behavior seen with schizophrenic psychosis cases." I have a clinical problem with that.

Q. Why is that?

A. Because cocaine psychosis is something which involves -- which certainly involves intermittent intrusive thoughts,

almost a -- a waxing and waning, of people sort of beginning to exert some control and then losing control of their thought processes, paranoid ideation, sometimes auditory hallucinations and the impulsivity. It certainly waxes and wanes with cocaine psychosis. And as I said, it's one of the reasons why it's so easy from a clinical standpoint to underestimate a patient's dangerousness, for example in the Emergency Room, and to, therefore, take them less seriously than one needs to and then have the person accelerate ten or fifteen minutes later and become extremely dangerous. That is not only my clinical experience, but in the literature and from the literature from the early '80s about cocaine psychosis. And, therefore, the fact that this patient at the time exhibits clearly disorganized -- although in this expert's opinion not grossly disorganized -- but clearly disorganized, clearly erratic, clearly inconsistent behavior with everything in his life, the best I could tell and most other experts, and very savage behavior. I think it's there.

Q. If I understand your testimony correctly, do you take exception to Dr. Reardon's descriptions as either savage or disconnected?

A. Yes, I take exception. I think that the record certainly indicates disorganized thinking and behavior, very erratic behavior, quite inconsistent behavior not only during the evening but entirely inconsistent behavior from -- comparing

the evening to his life leading up to there, and a degree of violence and savagery which is shocking, and I think that's all in the case and that is what I see in the case.

Q. And in addition to the descriptions that you take exception to, do you also take exception to the conclusions drawn there by Dr. Reardon?

A. Yes, I do. I read the beginning of the sentence of Dr. Reardon. The description that Mr. Hicks provided is not indicative of someone who was in such a state of cocaine psychosis. I interpret that as an opinion that the patient probably was in a state of cocaine psychosis, but that this person's opinion is that the extent was not great enough to be considered to contribute to the behavior, and I take exception to that conclusion.

Q. Now, Dr. Parran, again as an individual with the experience in cocaine and cocaine psychosis and matters surrounding cocaine, do you have an opinion as to whether or not Dr. Reardon is competent to offer an opinion with respect to cocaine psychosis and its effects?

A. I have some concerns, and let me tell you my concerns. In reading through his deposition yesterday, it concerned me that Dr. Reardon did not know the pharmacology of cocaine; didn't know the appropriate half life of cocaine; the duration of intoxication; didn't know that norepinephrine was the same thing as adrenaline, that they're the same thing;

didn't know that norepinephrine -- although he stated it was a neurotransmitter, which is partially true -- is actually a systemic hormone which when it is released from the brain functions as an neurotransmitter, but it is basically a systemic hormone throughout the body. He seemed to think the majority of cocaine effects were through sera -- he seemed to think the majority of euphoric effects were mediated through seratonin, when they are clearly by dopamine; did vaguely recall dopamine and thought that was involved in some ways but at least that's what I saw in the deposition. So that concerned me, from a knowledge of pharmacology standpoint.

The other thing that concerned me was his description of his clinical background in addiction medicine. He stated that although -- and certainly he was the clinical director or administrator, director of a big treatment program in the Columbus area for several years, he didn't know what ASAM, American Society of Addiction Medicine was. And, actually, treatment programs in Ohio that have medical directors who are not certified by ASAM, are not able to receive reimbursement by third-party insurers for the treatment they provide because it's considered that an ASAM-certified medical director is one way that insurance companies can verify that it's a legitimate and well-run treatment program. That concerned me that he didn't know what that was.

It concerned me he didn't know what an addiction medicine fellowship was, even though he is a psychologist and not a physician. Being an expert in the field or being able to give expert opinions about aspects of addiction medicine, cocaine psychosis, without even knowing what an addiction medicine fellowship is concerned me.

And then, finally, the description that he gave of the treatment program and the cocaine psychosis patients he's seen concerned me. My impressions -- and this is just an impression based on the -- the deposition as well as his CV, is that a significant amount of the treatment program that he supervised, which sounds like a big comprehensive treatment program, was Methadone maintenance, which is for heroin addiction, residential treatment, which certainly could be for cocaine addicts, but generally well after the cocaine psychosis is done, and outpatient treatment. And when he was asked whether he had seen patients who had cocaine -- who were acutely using cocaine -- and the question seemed to be framed sort of along the lines of in an Emergency Room setting, or whatever, he stated he certainly saw lots of patients in outpatient treatment within a matter of a few hours of using, or even patients who came in intoxicated, and that was his experience with patients with -- my impression was that was his statement of experience with patients with cocaine psychosis. Actually, certainly lots of patients who

have just used cocaine recently or just used it on the bus or at the corner to -- before coming into treatment, that happens all the time. But the ones who use cocaine just before they come to treatment and trigger cocaine psychosis don't walk in the door. They go off; they go off to get more cocaine. So, those statements concerned me significantly regarding his qualifications to give an expert opinion about something having to do with cocaine.

Q. Dr. Parran, how important, in your professional estimation, is it to have an expert knowledge of pharmacological effects of cocaine to be able to explain the dynamics and the impact of cocaine psychosis in a given instance?

A. Well, I think especially -- let me back up. It's perhaps not critically important to have a clear understanding of all the pharmacology of cocaine to be able to talk about cocaine addiction to some degree, although even that would be a serious liability. Not knowing the pharmacology -- really knowing it well -- of cocaine, and certainly psychologists do know the pharmacology of cocaine -- I worked with many psychologists in our V.A. treatment who know the pharmacology of cocaine quite well. But, not knowing the pharmacology of cocaine when we're talking about something that is different than cocaine intoxication, that is different than the cocaine crash and is this sort of peri-binge, paranoid, at times

psychotic period, I think is -- renders a person in not a solid position to give an opinion.

Q. And finally, Dr. Parran, in your professional opinion, how important is it to be familiar with or expert in the pharmacology of cocaine in understanding Mr. Hicks' condition in connection with the matters in this case?

A. I think it's very important and it -- not knowing the pharmacology of cocaine and also how the pharmacology of cocaine measures with the disease of addiction to produce typical patterns of cocaine dependence, cocaine binging, the kindling phenomenon, and paranoia and psychosis, not knowing that I think renders a person in -- in a very weak position to be able to give a credible opinion about this case.

Q. From what you read in the transcript of Dr. Reardon, did it appear to you that he had an appreciation of the kindling effect as you've described?

A. No. My initial reading when he was asked about the kindling phenomenon, it appeared to me it was the first time he ever heard of it. I can't say that for sure. But then his response of what his understanding of it was, he thought he had a vague understanding of it, some sort of understanding. I can read the exact thing if you want -- oops, there it is. Page 49:

"Do you know what the kindling effect is?"

"Answer: Kindling?"

"Question: Kindling, k-i-n-d-l-i-n-g."

"Answer: Not specifically. Not that term."

"Do you know what it refers to?"

"Answer: Well, I'm assuming it refers to something with regard to timing of onset and so forth."

The response indicated that he really did not know what kindling was at all.

Q. And how important in your estimation is or was the kindling effect insofar as Mr. Hicks' situation is concerned?

A. Well, the kindling effect is what explains the reason why some patients -- and apparently at least -- to the best of my professional opinion, in this case a patient can binge on a tremendous amount of cocaine at one time and finally trigger a certain cascade of symptoms in themselves. In maybe five percent of cocaine addicts, a person by binging on cocaine will trigger a seizure. And then in that five percent, almost every time they use cocaine after that, even if it is a small amount, they'll have a seizure thereafter, and that's the kindling phenomena.

In terms of this case, using a tremendous amount of cocaine in the few years previously, intermittent and huge binges triggered the paranoid ideation when using cocaine, explains the crux of how a person can do somewhere between three and five runs of I.V. cocaine in an evening and develop very bizarre, very savage, very disorganized behavior that

looks like cocaine psychosis, more than anything else clinically in a differential diagnosis. So I think it is really a critical issue.

MR. MEZIBOV: Thank you, Dr. Parran. That's all I have.

MR. WILLE: Nothing further, Your Honor.

THE COURT: Do I understand that when the kindling effect is invoked or occurs, that then the person will binge on I.V. cocaine?

THE WITNESS: The kindling effect can -- the phenomenon of kindling can affect several different -- several different parts of cocaine use. Certainly the phenomenon known as kindling can affect whether a person has a subsequent seizure after they've had one.

THE COURT: We know Mr. Hicks didn't have seizures.

THE WITNESS: Yes.

THE COURT: So let's talk --

THE WITNESS: The kindling effect certainly explains how people have significant paranoid ideation and psychosis-type actions.

THE COURT: As far as we know, that never happened prior to this time with -- of the murders with Mr. Hicks; do we?

THE WITNESS: Well, the description -- the description in the 1990 report of Dr. Baum -- I think that's

his name -- granted, that was after the fact and it was information gathered in 1990, but the description there of the cocaine dependence that Mr. Hicks had had in the previous few years did describe no violent behavior but certainly described intense binges that involved paranoid ideation, using by himself, using in solitary environments, no longer using socially with other people. All of which is, at least I read, is pretty strong evidence for that.

THE COURT: Well, the only information you have in that regard is the amount of --

THE WITNESS: I can try to look for it here if you want me to.

THE COURT: Well, do you have -- I understood that you based your opinion on the fact that he used his life savings to buy cocaine.

THE WITNESS: That was my opinion regarding cocaine dependence. My opinion regarding the fact that it's my opinion that he had significant paranoia with previous binges, previous heavy binges with cocaine, was based both on my interview with Mr. Hicks in 1995 as well as data from 1990 and Dr. Baum's record which he shifted his pattern of use to more and more solitary use by himself during these binges, which generally happens because of the paranoia coming on with heavier and heavier binges.

THE COURT: And when he is on a binge, the only

thing he is interested in is getting more cocaine?

THE WITNESS: That's what most patients describe.

THE COURT: Did Mr. Hicks?

THE WITNESS: Mr. Hicks did, yeah, and he described that in his --

THE COURT: So Mr. Hicks was on a binge?

THE WITNESS: Yes.

THE COURT: And all he was interested in was getting more cocaine?

THE WITNESS: That -- that sounds --

THE COURT: Am --

THE WITNESS: I mean, that seemed to be my reading of it.

THE COURT: All right. All right. Now, when did he start the binge?

THE WITNESS: I'll have to look at it, but it's -- from the detective's report, I believe -- I have it right here. He first used --

THE COURT: Well, I thought --

THE WITNESS: I'm sorry, Your Honor, but it's -- I thought it was about 8 o'clock in the evening.

THE COURT: On the Friday?

THE WITNESS: On Friday.

THE COURT: After --

THE WITNESS: Between 8:00 and 9:00 in the evening,

I think.

THE COURT: All right. And that's when the binge started?

THE WITNESS: That was the first use of cocaine.

THE COURT: Now, when did the binge start? I understand there is a difference between the simple use of cocaine, if there is such a descriptive phrase, and a binge.

THE WITNESS: What I would say is that once a person has cocaine dependence and they've -- and they've established it in a binge-crash pattern, which is the most common, the initial use of cocaine is the initial start of that binge.

THE COURT: All right. So, then if Mr. Hicks' situation was such that if he took a drop or a -- any amount of cocaine, it was the start of a binge?

THE WITNESS: That's consistent with the history that I heard in here, especially from Dr. Baum and my history with him.

THE COURT: And so the binge started with the first use of cocaine?

THE WITNESS: Yes.

THE COURT: When did it end?

THE WITNESS: Usually we classify the binges ending with the last use of cocaine.

THE COURT: Last use. So --

THE WITNESS: Maybe ten minutes after that, when the peak goes away.

THE COURT: Now, in this situation the binge was over with the last use of cocaine?

THE WITNESS: I would say, yes.

THE COURT: Around 12:30 that evening?

THE WITNESS: Yeah, I think it was right around then, 12:30. Maybe -- let's see. Oh, must have been 12:30; something like that. "So, I went up ahead and shot up the dope I got." So, I think he went around 12:30 and got his last cocaine and came back to the apartment and used it. So, probably sometime between 12:30 and 1:00 or so.

THE COURT: Thank you.

THE WITNESS: Okay.

MR. MEZIBOV: Your Honor, may I clarify one point?

FURTHER REDIRECT EXAMINATION

BY MR. MEZIBOV:

Q. Dr. Parran, His Honor has asked the onset and the duration of the cocaine binge; correct?

A. Yes.

Q. And what about the onset and the duration of the cocaine psychosis?

A. Most patients -- and I can't say for Mr. Hicks, because by the time I interviewed him in 1995, he said that his recollection of all of the events that evening was not clear

enough to tell me exactly. But, most patients, once they have had cocaine psychosis or paranoia associated with the cocaine binge in the past, get some degree of paranoia, usually mild, after the first use of cocaine and then it is multiplied each time they use the cocaine thereafter. So, I generally consider serious paranoia to be starting after the second time that people use cocaine.

Q. When in connection with Mr. Hicks then would the serious onset of psychosis set in?

A. Once again, the only thing I have to base my opinion on is his confession, and during his confession he said he got edgy, he got restless, that he got an incredible urge to use cocaine after the first I.V. cocaine use and he went and hocked the VCR. When he used the second I.V. cocaine, he suddenly started thinking about robbing his grandmother -- or his mother-in-law; and as that got closer, he began considering murdering his grandmother, and that -- so clinically for me it would be right around the time or shortly after the second I.V. administration of cocaine.

Q. And do you have an opinion, to a reasonable degree of medical certainty, whether Mr. Hicks was in the midst of a cocaine psychosis throughout the times these two murders were committed?

A. Yes.

MR. MEZIBOV: Okay.

MR. WILLE: Nothing further, Your Honor.

THE COURT: Is this witness released?

MR. MEZIBOV: Yes, Your Honor.

THE COURT: Is this witness released?

MR. WILLE: Thank you. Yes. Thank you, Your Honor.

THE COURT: Thank you, Doctor.

(Witness excused.)

THE COURT: We'll have a 15-minute recess.

THE CLERK: All rise.

(At 2:43 p.m., a recess was taken.)

* * * (3:05 p.m.)

THE COURT: Is the petitioner ready to proceed?

MR. MEZIBOV: Yes.

THE COURT: Respondent ready to proceed?

MR. WILLE: Yes, Your Honor.

THE COURT: Call your next witness.

MR. MEZIBOV: Your Honor, we've agreed with Mr. Wille that we can call certain witnesses out of order, and we defer to Mr. Wille.

THE COURT: Proceed.

MR. WILLE: Thank you, Your Honor. We would call Dr. Reardon.

THE CLERK: Raise your right hand, please.

(Duly sworn by the Clerk.)

IN THE COURT OF COMMON PLEAS
TRUMBULL COUNTY, OHIO
CASE NO. 01-CR-794

STATE OF OHIO	:	
Plaintiff	:	Case No. 01-CR-794
-vs-	:	
NATHANIEL JACKSON	:	
Defendant	:	

EXHIBIT_____

AFFIDAVIT OF ROBERT G. KAPLAN, PH.D.

STATE OF OHIO :
: ss:
COUNTY OF CUYAHOGA :

Robert G. Kaplan, Ph.D., after being duly sworn according to law states as follows:

1. I am a clinical and forensic psychologist licensed to practice psychology in the State of Ohio, with professional offices located in Cuyahoga County, Ohio.
2. My professional background and qualifications are set forth in my Curriculum Vitae which is attached and made part of herein as Exhibit "A".
3. One of my professional specialties is the assessment and treatment of substance abuse.
4. I have reviewed, regarding the defendant, Nathaniel Jackson, several documents which contain the following information about him:
   a. Nathaniel Jackson abused crack cocaine and wanted to stop abusing this substance.
   b. Nathaniel Jackson stole to support his drug habit.

assuming that it is correct, it can be stated, with reasonable psychological certainty that Mr. Nathaniel Jackson requires an evaluation in order to determine if he has a substance abuse problem, if he is chemically dependent and/or if he has any mental disorder.

6. Based upon the information listed above in paragraph four of this affidavit, and assuming it is correct, it can be stated, with reasonable psychological certainty, that Mr. Nathaniel Jackson requires an evaluation in order to determine if any substance abuse problem, chemical dependency problem, and/or any mental disorder was a contributing or mitigating factor with regard to the instant offense.

7. I am available and able to conduct a psychological evaluation of the defendant for the purposes stated in paragraphs five and six of this affidavit.

8. My fees for conducting a psychological evaluation are set forth in my Fee Schedule which is attached and made part of herein as Exhibit "B".

9. I will charge a per-diem rate of $2400.00 (two-thousand, four-hundred dollars and zero cents) for the time that I spend evaluating the defendant and estimate that it will take no longer than one day to evaluate the defendant, including travel time.

10. I will charge an hourly rate of $300.00 (three-hundred dollars and zero cents) per hour for the time that I spend reviewing any additional documents and records, consulting with counsel, and writing any additional reports. I estimate that it will take two to four hours of additional time to review documents and records, two to four hours of additional time to consult with counsel, and one to two hours to write a report of my evaluation.

11. I will charge a fee of $150.00 (one-hundred, fifty dollars and zero cents) per psychological test that I administer to the defendant. I estimate that I will need to administer three to four tests.

12. I will charge a per-diem rate of $2400.00 (two-thousand, four-hundred dollars and zero cents) for the time that I spend testifying outside of Cuyahoga County, Ohio. I will charge an hourly rate of $300.00 (three-hundred dollars and zero cents) for any video-taped testimony provided in Cuyahoga County, Ohio, with a two-hour minimum charge.

Further affiant saith naught.

ROBERT G. KAPLAN, PH.D.

NL Rm733061

Sworn to and subscribed in my presence this twenty-sixth day of December, 2003.

NOTARY PUBLIC

ANNETTE DEL PIZZO
Notary Public, State of Ohio, Cuy. Cty.
My commission expires Mar. 21, 2007

Curriculum Vitae

Dr. Robert G. Kaplan
Clinical Psychologist
Board Certified Forensic Examiner
Fellow, American College of Forensic Examiners
Diplomate, American Board of Psychological Specialties,
Psychological Disability Evaluation

Kaplan Consulting & Counseling, Inc.
3401 Enterprise Parkway, Suite 340
Cleveland, Ohio 44122-7340
Call: (216) 766-5743
Fax: (216) 766-5796
Email: Rkaplan@KaplannCC.com
Internet: www.KaplanCC.com

Current Employment Position

President, Kaplan Consulting & Counseling, Inc. (April, 2002 to Present)

A forensic psychologist who specializes in trauma, psychological disability evaluation, workplace violence, sexual harassment, discrimination, substance abuse prevention and criminal behavior. He is an experienced crisis manager who has successfully helped employers and individuals resolve several hundred crises involving suicidal, homicidal, intoxicated and psychotic individuals without the loss of a single life throughout his career. He also advises employers on the development of policies, programs and strategies in his areas of specialization. In his private practice he specializes in treating individuals who suffer from trauma, substance abuse, depression and anxiety.

Previous Employment Positions

Executive Vice President, Behavior Management Associates, Inc. (May, 1985 to April, 2002)

A founding principal of a firm that provides employee assistance programs, managed behavioral health care services, organizational training and development programs, and evaluations for hiring and promotion to over 200 employers across the United States and Canada. Services were provided to over 250,000 covered lives of the firm's ***IMPACT*** Employee Assistance Program. The firm also provides psychological assessment and counseling services to individuals, couples

and families in the greater Cleveland metropolitan area. His responsibilities included the management of forensic and assessment services, clinical services, crisis intervention services, program development, employer policy consultation, risk management, information and communication technology, contracting, and development of marketing materials.

Psychologist, Management Psychologists of Ohio (December, 1983 to June 1984, Part-time, July, 1984 to May, 1985)

An employee of a firm that provided management consulting and employee assistance programs to employers in the greater Cleveland metropolitan area. Responsibilities included individual, group, family and marital psychotherapy, biofeedback, psychological assessment and vocational counseling. Extensive assessment services were provided for attorneys, insurance and rehabilitation companies, employers, the Ohio Bureau of Workers Compensation, the Ohio Bureau of Vocational Rehabilitation and the U.S. Social Security Administration.

Counselor, City of Cleveland Office of Mental Health & Substance Abuse (October, 1982 to June, 1984)

An employee of a city agency that provided outpatient mental health and substance abuse services primarily to low-income, poor and indigent residents. Responsibilities included individual, group and marital psychotherapy, outreach services, social services, substance abuse counseling and consultation to medical staff in the adult and adolescent clinics of the Thomas F. McCafferty Health Center, an inner-city outpatient health care facility. Psychological assessment and consultation services were performed for agency staff located throughout the City of Cleveland. Additional responsibilities included group therapy for substance abusers, individual psychotherapy, and psychological assessment of prisoners in the City of Cleveland House of Corrections.

Internship

Cleveland MetroHealth Medical Center (Formerly Cleveland Metropolitan General Hospital, September, 1981 to September, 1982)

Psychology Intern at a county teaching hospital of Case Western Reserve University Medical School, accredited by the American Psychological Association. Responsibilities included psychological assessment and neuropsychological testing of infants through elderly on both inpatient and outpatient units, individual outpatient psychotherapy of children, adolescents and adults, crisis intervention and emergency services, group psychotherapy of inpatient adolescents, psychological consultation to pediatric and adult medical wards, psychological assessment and intervention with medical patients, psychological support to medical staff, case management of adolescent and adult psychiatric inpatients, and provision of psychological services to multi-disciplinary treatment teams for adolescent and adult psychiatric inpatient units.

Training Placements

Case Western Reserve University Student Health Service (September 1980 to September, 1981)

Psychology Assistant at a university counseling center. Responsibilities included outpatient psychotherapy with graduate and undergraduate students of the university.

Cleveland Veterans Administration Medical Center (September, 1978 to September, 1980)

Psychology Assistant at a large Veterans Administration psychiatric hospital. Responsibilities included one year of providing psychological services for an acute-care psychiatric ward, six months of providing psychological services for the drug dependency treatment unit, six months of providing psychological services for the day hospital program (full-day treatment of hospital outpatients). Services included psychological assessment, individual and group psychotherapy, case management, therapeutic community intervention, biofeedback and multi-disciplinary treatment team planning.

Lake County Mental Health Center (September, 1977 to September 1978)

Psychology Assistant at a large suburban mental health center. Responsibilities included individual and group psychotherapy, crisis intervention and psychological assessment of children, adolescents, adults and elderly county residents.

Education

Ph.D., Clinical Psychology, 1983, Case Western Reserve University, Cleveland, Ohio

M.A., Clinical Psychology, 1981, Case Western Reserve University, Cleveland, Ohio

B.A., Cum Laude, Psychology, 1976, University of Pennsylvania, Philadelphia, Pennsylvania

License and Certifications

Psychologist, State of Ohio, License Number 3518, 1984

Fellow, American College of Forensic Examiners, 1999 to Present

Diplomate, American Board of Psychological Specialties, Psychological Disability Evaluation, 1996

Board Certified Forensic Examiner of the American College of Forensic Examiners, 1996 to Present

Diplomate, American College of Forensic Examiners, 1996 to 1999

U.S. Dept. of Transportation Substance Abuse Professional 1998 to Present

Critical Incident Stress Debriefing, International Critical Incident Stress Foundation, 1995 to Present

CPR & First Aid, American Red Cross, 1998 to Present

Hospital Affiliations

University Hospitals Health System, Laurelwood Hospital, Cleveland, Ohio, 1992 to Present

Parma Community General Hospital, Cleveland, Ohio 1996 to Present

Professional Associations

President, Cleveland Psychological Association, 1999

Treasurer, Cleveland Psychological Association, 1998

Chief, Information & Referral Service, Cleveland Psychological Association, 1998

Chairperson, Speakers Bureau, Cleveland Psychological Association, 1997

Chairperson, Public Education & Marketing Committee, Cleveland Psychological Association, 1997

Member, International Society of Traumatic Stress Studies, 1994 to Present

Member, Cleveland Psychological Association, 1985 to Present

Member, Ohio Psychological Association, 1985 to Present

Member, American Psychological Association, 1985 to Present

Member, Employee Assistance Professionals Association 1985 to Present

Member, Program Committee, Employee Assistance Professionals Association, Northern Ohio Chapter, 1985 to 1987

American Management Association 1985 to 1987

Teaching Experience

Guest Lecturer, Critical Incident Stress Debriefing, Cleveland State University, Cleveland, Ohio, 1997

Instructor, Behavior Modification, Ursuline College, Cleveland, Ohio, 1987

Graduate Assistant, Psychological Assessment, Case Western Reserve University, 1980-1981

Undergraduate Assistant, Statistics, Case Western Reserve University, 1980-1981

Professional Publications

Kaplan, Robert G., (1998) Preventing Workplace Violence, in *The Best of Labor & Employment Law, 1997, Volume #703,* Carl F. Muller, Ed., Columbus, Ohio, Ohio CLE Institute Publications

Workplace Violence Technical Advisor, Gustin, Joseph F. (1996), *Safety Management, A Guide for Facility Managers*, New York, New York, Upword Publishing, Inc.

Weiner, Irving B., & Kaplan, Robert G., (1978), Supervising the Beginning Therapist, in *Psychotherapy Supervision: Theory, Research and Practice*, New York, New York, John Wiley & Sons, Inc.

Government Consultation

Consultant and Expert Witness, Personal Injury, Office of the Attorney General of Ohio, 2003

Expert Witness, Personal Injury, Department of Justice, Canada, Winnipeg, Manitoba, 2002

Expert Witness, Death Penalty, Federal Public Defender, Phoenix, Arizona, 2002

Consultant, Police Homicide, Erie County Prosecutor's Office, Buffalo, New York, 1999

Expert Witness, Death Penalty, Indiana Public Defender's Office, Indianapolis, Indiana, 1997 to 1999

Consultant & Expert Witness, Workers' Compensation, Greater Cleveland Regional Transit Authority, 1997 to Present

Volunteer Mediator, City of Lakewood Prosecutor's Office, Lakewood, Ohio, 1990 to Present

Consultant, Stress Management, U.S. National Aeronautics and Space Administration, John Glenn Research Center, (formerly Lewis Research Center), Cleveland, Ohio 1986 to 1988

Expert Witness, Juvenile Homicide, Cuyahoga County Prosecutor's Office, Cleveland, Ohio, 1985

Consultant, Ohio Bureau of Workers Compensation, Cleveland, Ohio 1984 to 1986

Consultant, Ohio Bureau of Vocational Rehabilitation, Cleveland, Ohio 1984 to Present

Consultant, U.S. Social Security Administration, Cleveland, Ohio1984 to 1986

Community Affiliations

Founding Board Member, Cuyahoga County Critical Incident Stress Debriefing for Emergency Responders, Cleveland, Ohio, 1995

Volunteer Coordinator, Mental Health Disaster Team, American Red Cross, Cleveland, Chapter, 1992 to Present

Board Member, Cleveland Clinic Foundation Children's Hospital Advisory Board, 1990 to 1992

Board Member, Glenbeigh Chemical Dependency Hospital Community Advisory Board, Rock Creek, Ohio, 1990 to 1992

Board Member, Adam Walsh Foundation for Missing Children, Cleveland Chapter, 1987

Professional Presentations (Partial Listing)

Verifying Psychological Claims, VocWorks Employer Seminar, Cleveland, Ohio October, 2003 and Youngstown, Ohio October, 2003

Better Evaluation & Management of Candidates and Employees, Ohio Staffing Services Association, Cleveland, Columbus, Cincinnati, and Dayton, Ohio, September, 2003.

Workplace Violence Prevention, Ohio Bar Association, Columbus, Ohio, August, 2003

Psychological Issues and the Law, 16th Annual Labor and Employment Conference, Benesch, Friedlander, Coplan & Aronoff, LLP, Cleveland, Ohio, May 16, 2002

Take a Proactive Approach to Protecting Your Company and Employees From Workplace Violence and Conflict, Personnel Law Update, Council on Education in Management, June 20, 2000

Stress Management, Healthy People: Mental Health Program, The Health Museum of Cleveland, February 8, 1997

Critical Incident Stress, Business and Industry Council for Emergency Planning and Preparedness, American Red Cross, Cleveland, Ohio, January 14, 1997

Violence in the Workplace and the Impact it has on Victims and Their Families, In Your Interest, WQHS-TV, Silver King Broadcasting, Cleveland, Ohio January 10, 1997

Preventing Violence in the Workplace: The Growing Threat That Can Happen Anywhere at Any Time, 1996 Ohio Employment Law Seminar, Ohio Chamber of Commerce & Manufacturers Education Council, Columbus, Ohio, October 22, 1996

The Human Equation, Business Survival and Recovery Seminar, Contingency Planners of Ohio, Cleveland, Ohio, October 15, 1996

Managing Employees After a Branch Robbery, Robbery Seminar, Star Bank, Cleveland, Ohio, September 24, 1996

Stress Management, Future Leaders of Medina County, Medina County Schools, Medina, Ohio, March 7, 1996

Diagnosis & Treatment of Anxiety Disorders with Particular Emphasis on Post Traumatic Stress Disorder, Continuing Professional Education, Cuyahoga Community College, Cleveland, Ohio, March 5, 1996

Substance Abuse Prevention, Representing Closely Held Businesses, Cohen & Company, Cleveland, Ohio, November 14, 1995

Dealing with Catastrophic Stress, Business Disaster Recovery, Contingency Planners of Ohio, Cleveland, Ohio, July 19, 1995

Workplace Violence Prevention, Crime and Violence in the Ohio Workplace, Institute of Business Law, Cleveland, Ohio, May 17, 1995

Evaluation of Emotional & Psychological Distress, 1995 Spring Meeting Program, Ohio Association of Civil Trial Attorneys, Columbus, Ohio, May 12, 1995

Workplace Violence Prevention, Crime and Violence in the Ohio Workplace, Institute of Business Law, Columbus, Ohio, May 10, 1995

Managing Traumatized Employees, Disaster Planning Symposium, American Red Cross, Cleveland, Ohio, March 21, 1995

Managing Distressed Employees, Annual Meeting, Personnel Association of Central Ohio, Columbus, Ohio, January 12, 1995

Warning Signs: How to Identify and Intercept Potential Violence, Preventing Workplace Violence, Council on Education in Management, Cleveland, Ohio March 30, 1994
Safe Handling of the Volatile Employee, Personnel Law Update, 1994, Council on Education in Management, Cleveland, Ohio, January 28, 1994

Emotional Damages and Claims of Sexual Harassment, Labor & Employment Law Seminar, Duvin, Cahn, Barnard & Messerman, Cleveland, Ohio, October 28, 1993

Controlling Emotional Damages in Catastrophic Cases, Joint Seminar, Mississippi Claims Association & Mississippi Defense lawyers Association, Jackson, Mississippi, April 30, 1993

Substance Abuse Prevention Program, Drug Testing and Litigation: Understanding the Process, Ohio State University Continuing Legal Education, Cleveland, Ohio May 8, 1992

Training Programs Developed & Presented

Substance Abuse Prevention (For Employees & Managers)

Sexual Harassment Prevention (For Employees)

Stress Management (For General Public)

Traumatic Stress, Post Traumatic Stress Disorder & Critical Incident Stress Debriefing (For Mental Health Professionals)

Dealing with Catastrophic Stress (For Managers)

Dealing with Victims of Catastrophic Claims (For Insurance Adjusters)

Managing Distressed Employees (For Managers)

Coping with Change (For Managers)

Making the Most of Differences Between Yourself & Others (Diversity Training for Employees)

Proving & Disproving Emotional Damages (For Attorneys)

Dealing with Volatile Customers (For Employees)

Dealing with Volatile or Difficult People (For General Public & Employees)

Workplace Violence Prevention (For Employees & Managers)

Verifying Psychological Claims (For Attorneys & Claim Represenatives)

Media Appearances

Wall Street Journal (September 11, 2001, Working in Tall Buildings)

Cleveland Plain Dealer (Employee Assistance Programs, Stress Management, Workplace Violence)

Inside Business Magazine (Psychological Effects of Economic Change in Cleveland, Ohio)

WKYC-TV3, Cleveland, Ohio (September 11, 2001, Murderers, Seasonal Affective Disorder)

WJKW-TV8, Cleveland, Ohio (September 11, 2001, American Red Cross) Named to "America Responds" Team for features on coping with terrorism

WEWS-TV5, Cleveland, Ohio (September 11, 2001, Post Traumatic Stress Disorder)

EXHIBIT "B"

PROFESSIONAL FEE SCHEDULE OF ROBERT G. KAPLAN, PH.D.

Kaplan Consulting & Counseling, Inc.

Fees for Forensic Evaluation, Consultation and Testimony

Evaluation	
Diagnostic Evaluation	$300/hr.
Record Review & Analysis	$300/hr.
Report Preparation	$300/hr.
Consultation in Person or by Phone	$300/hr.
Psychological Tests	$150/test
Testimony	
Deposition Testimony*	$300/hr. (2 hr. minimum)
Court Testimony*	$300/hr. (4 hr. minimum)
Preparation for Testimony	$300/hr.
Other Charges	
Per Diem for Evaluation or Testimony	$2,400/da. (8 hr. maximum)
Local Travel Time**	$300/hr. Portal to Portal
Non-local Travel Time	$1,200 flat rate each way per separate day
Record Copying	$0.20/copy plus $25/hr. Administrative and Secretarial Time

Retainer Policy

$3,000 Must be prepaid and will be charged at prevailing rates. Unused portion will be refunded.

Retainer not required for government entities.

*Fees for testimony are non-refundable and must be paid seven days in advance to reserve time.

** Local travel time applied for locations within 60 miles of Beachwood or Lakewood, Ohio offices. Non-local travel time applied for locations outside of 60 miles of Beachwood or Lakewood, Ohio offices.

LARRY SOUTHWICK STATEMENT TO
HOOLIHAN & DILLON AT W.P.D.

Larry Southwick, date of birth is [redacted] Social is [redacted]. He lives at [redacted]. He works full time at MedStar Ambulance as a dispatcher. He is currently the manager of the Warren terminal of the Greyhound Station.

Larry has worked for Fingerhut since 1998. At that time there was a West Warren Terminal. He worked as a ticket agent in the mornings from 8:30 until 12:00 at which time Fingerhut would come in. They would close the terminal, go to lunch together and then re-open the station. Larry then went to his regular job at 1:00.

Larry helped Fingerhut move the West Warren station to it's current location on East Market. In the process of moving Larry asked Robert what was in the bag (which was in a box of stuff they were moving). He told him it was a gun and showed it to him. Larry describes it as a .38 revolver that was silver with light brown handles. In the bag also were an eyeglass repair kit, ammunition and a couple of knives. Larry said this bag was always at the terminal in a little cubbie hole in the wall. When Fingerhut worked it was either in the back office with him or near his briefcase.

Either Robert or Donna would call in to the terminal everyday to see if everything was all right with Larry. He didn't actually meet Donna for approximately 4-6 months after coming on board. Larry describes Robert as a good boss who was laid back and a fair payer. Larry wasn't aware of any relationships outside of the marriage. Robert introduced Donna as his 'wife'. He said that they argued from time to time, like normal couples.

Larry said that Donna spent a lot of time back then at the Youngstown terminal. There was a restaurant in the terminal called Just The Ticket where Donna was most of the time. Apparently she's been arrested at least a half dozen times in that restaurant. He could only recall why on one occasion. The charge was obstruction of justice. There was a white security guard that was always hassling the black customers and Donna would go off on him. Her arrest was the result of this. When Donna would call Robert to bail her out he would call her an idiot and tell her he wasn't going to bail her out.

EXHIBIT
65

The hours of the Youngstown station are approximately 7:00, 7:30 to 9:00, 9:30.

Larry quit the terminal in 2000 because some phone cards came up missing from the safe and Robert blamed him. Robert said it had to be one of Larry's family members or someone he let in the back. He repeatedly said this to Larry and Larry finally wrote Fingerhut a letter and quit. Fingerhut only listed Larry's name as a possible suspect on the arrest report. Larry said he even had some of his own money (rolled coin) in the safe and why would someone leave that behind and just take the cards. Donna let people back there, even passengers (as was witnessed by Larry's wife). Even inmates were in there a lot. Several times a week TCI would bring inmates to the terminal who had been released. Larry quit in October of 2000.

Donna called him to come back to work in November of 2000. Robert wanted him to come back as well and told him he could when things picked up. However, he didn't go back until the Saturday after Robert's funeral.

Larry said there was no indication of marital problems. Fingerhut joked once about "she must have a boyfriend' after a telephone call with Donna. That was a couple of months ago, Larry said.

When Larry came back on December 15th, the bag with the gun was in the cubbie hole. He didn't look inside at that time. The following Monday he looked and sure enough, the gun was gone. He called the Howland Police Department to report it missing.

Larry attended the funeral and said Donna was crying the whole time. She met with him afterwards (at the funeral) and gave him the keys to the Warren terminal to open up the next day.

Larry didn't know of any boyfriends of Donna's and had never seen or heard of Nate. He did witness her writing a long letter a week before Robert's death. He didn't know if Donna carried a gun or not. The target in the terminal was from a target practice she attended next door to the old West Warren terminal. There is apparently a shooting range there.

There was a computer at the Warren terminal with internet access. Larry never witnessed Donna on it.

Larry first heard about the Santiago-gun incident after Fingerhut was murdered.

When police asked him if he thought Donna would have any use for the missing phone cards he said she could use them for private, untraceable calls if she wanted to. He never witnessed this though.

At night, Robert and Donna, would take the daily cash home with them and one would deposit it in the morning on their way to work.

Larry said that Fingerhut was distanced from his son in Florida and that he didn't trust any members of his family.

Larry didn't know EVERYTHING was in Donna's name, only the Greyhound business. Larry was told it would be harder for someone to sue them if it was in Donna's maiden name. Larry also thought Donna was laid back and easy going.

Larry said Fingerhut really liked eBay and that's where he got all the team jackets and other sports memorabilia.

Larry called Donna after the funeral to console her. They never discussed the actual death. Talked about 3 times just consoling. She then asked him to run the station because he was the only one in Warren who knew how and she trusted him.

Larry never saw any bullet holes in the basement of the Warren terminal. He said they weren't there when they moved to the new location.

Robert never mentioned Nate and Larry never saw them together.

Jenny Smith is Larry's Sales Manager. She heard from both, Jamie Wozak for the Akron terminal and Melvin, from the Youngstown terminal that driver (the 5:15 bus), Jimmy McCoy, told them that jokingly he said, upon coming into the Warren terminal and finding Donna on the computer, "You're in a chat room talking to your boyfriend again". And she replies "My man, Nate, is in the back". At that point Nate comes from the back office to the front office. This was one week before the homicide. (???)

CHRISTINE ELLINGTON
INTERVIEW WITH HOOLIHAN AND DILLON (H.P.D) AT THE W.P.D.

Christine owns The Final Cut hair salon at 402 East Market. She lives in Liberty and her Social is [redacted], date of birth is [redacted] Hours are 9-5 on Tuesday thru Friday, and 7-4 on Saturdays. Closed Sunday and Monday.

She had seen Donna and knew she worked at the Greyhound Station.

Donna brought Nate in on the 11th and said "Here's another cut".

Christine said she didn't converse with Nate at all during the cut because it slows her down and the fact that she didn't know Nate. Donna went back to the terminal.

Chris said Nate was wearing dark clothing, and paid for the cut himself ($13.00).

Christine said that Donna has brought 3 or 4 black guys in for cuts previously and all she would ever say was "I have a cut for you".

Christine said she had never seen Fingerhut and Nate together.

EXHIBIT 66

01-32813

WARREN MUNICIPAL COURT
141 South St., Warren, Ohio 44483

STATE OF OHIO
CITY OF WARREN

CASE NO. 01CRB2570

VS.

COMPLAINT (Rule 4)

SANTIAGO MASON
Name [redacted]
Soc. Sec. # [redacted]
D/O/B [redacted]
Warren, Ohio 44483
Address
Sex

Complainant being duly sworn states that SANTIAGO MASON
Def. Name

at CITY OF WARREN Trumbull Co., Ohio; on or about November 20 20 01

State essential facts

did with purpose to deprive the owner, Donna Roberts, one(1) .38 cal Smith & Wesson handgun, Three Hundred Twenty Dollars in U.S.Currency and telephone cards the value being over $500.00 knowingly obtained or exerted control over said property by deception

in violation of ORD/ORC ORC 2913.02 THEFT F 5th dg

complainant Donna Roberts

address

Complainant Signature

Sworn to and subscribed before me on NOVEMBER 23 20 01

Judge - Clerk - Deputy Clerk - Notary

WARRANT ON COMPLAINT

To _____ You are ordered to arrest above defendant and bring him/her before this court without unnecessary delay. You may/may not issue a summons in lieu of arrest under Rule 4 (A) (2) or issue summons after arrest under Rule 4 (F) because _____

State reason if restricted

Judge - Clerk - Deputy Clerk

****

SUMMONS ENDORSEMENT

This warrant was executed by arrest/by issuing the following summons:
You are hereby summoned and ordered to appear at _____ o'clock ____ M. on _____ 20____ at Warren Municipal Court. If you fail to appear at the time and place stated above you may be arrested.

Issuing Officer - Title

EXHIBIT 67

Highlight of the notes of the tape of Santiago Mason at the Prosecutor's Office. Detective Hoolihan and Detective Dillon (Howland P.D.) took this statement.

Santiago is married and he has one kid. He apparently goes to the Greyhound bus station in Warren where he was going to purchase a ticket to go to Cleveland to visit his relatives the next day. As he is at the window, he approaches Donna and she is sitting there writing a letter. He sees a picture of a black guy and it looks like he is in incarcerated. Santiago recognized the bars, because they were both apparently housed in Belmont. They didn't know each other though. He buys the ticket and then Donna starts coming on to Santiago pretty heavy. Telling him, "You are so cute. I always liked black guys cause they got big dicks." Santiago in turn says, "I got a big dick." One thing leads to another and she is asking him "Can we hook up later on tonight. I get off work at 5:00, why don't you come back down to the station at 5:15 and we'll hang out. Maybe go to my house." So, Santiago goes back to the Greyhound station at 5:15 and he goes around to the front door and she tells him to go to the back door where she comes out and tells him she will be right out, she has to lock everything up. They get

in the car and Donna fires up a bad ass joint. They get to Donna's house and apparently they are in the living room. They are only there for about 45 minutes. Donna proceeds to say, "Let me see how big your dick is." Santiago gets his tool out and Donna has her way with it and she is begging him, "Why don't you fuck me. Why don't you fuck me." Santiago says, "No." He keeps saying no. He's mumbling about he doesn't want to get any disease or anything like that cause he is married. Anyway, Donna finally gets pissed off and Santiago wants to go back to the Greyhound station, he's asking questions about Donna's husband, whether he will be home or not and he was real nervous about being there seeing that he just met her that same day and here he is in her car, in her big house, getting high with her and having sex with her to an extent. Just oral sex on Donna's part.

Donna tells him that Nate...she is always going on about Nate, how much she loves him and how much he loves her and she can't wait until he gets out... That her and Fingerhut don't even sleep in the same rooms, they are actually separated, but they are just living in the same house. She tells him she doesn't want a divorce because everything is in her name. Donna tells him that Nate is going to shoot some guy that's been hitting on her and later on in the tape, it reveals that this happened before Nate went to prison. He

and Donna were in a car and a gang of black guys comes over and they are like sizing her up and saying stuff and that's what that led to. Since they were hitting on Donna he was going to shoot them.

She takes him back to the Greyhound station and he walks home and then two or three days later, Donna calls him and Santiago apparently had her cell phone number. She gave it to him. He actually rattled it off by heart during his interview. She calls him and tells him she wants to see him and suck his dick again. Apparently, they end up going to meet back at the Greyhound station and Santiago comes of course and they get in the car and she is listening to this wild rap music and he was laughing, "What you doing woman? Listening to music like that!" She's all old and everything you know. (Santiago) On the way there, Donna is asking Santiago why don't you drive and he says I drive, I have a car, I just don't have a license. I have fines and costs and it is going to cost money to get unsuspended or whatever and she says, "Well, I will loan you the cash. If you want so you can get your license back." He was like, "Cool, that works for me." She reaches in her pocket and gives him $220.00, by this time they are back at the house. They are in the other living room this time, Donna performs oral sex on him again and she says, "Don't worry about the money honey. I don't ever have

to worry about money. I don't worry about money at all. When you gonna fuck me?" Again he says, "No." She gets mad and she goes back to the bedroom and comes out with another joint and she is smoking it. They were only there at the house for 20 to 25 minutes. She is still mad, so she takes him back to the station and then about one week later she shows up at his place of employment, Vista Windows, (Elm Road? Old Stambaugh Thompson's behind Perkins, I am not real sure) Anyway, she is all irate, she's mother fucking him up and down and screaming, "I want my money back!" There was a couple of witnesses there, his friend Wali, he spends every night over at his house in the evenings. Another guy name Walt. She is going on and on, mfing him, "You got my money and my gun!" Santiago is like, "Your gun? I don't have your gun, I don't have your money." She is saying, "I am going to have you fucked up." So they keep interrogating him about whether they ever stopped anywhere, have they ever just stopped anywhere at all, other than just go to the Greyhound and straight to her house and back and Santiago is adamant that they have never stopped anywhere. Including the Dairy Mart where supposedly the gun was stolen from her and the money. He swears he has never seen any envelopes or any bags, never saw a gun, he never stopped, but Donna did tell him at one point earlier on the first ride that she kept two guns in the car. She ends up telling

him that she is going to call the police and she filed that report on him November 20th, missing Smith and Wesson 38, phone cards, and cash. He told the detectives that before she wasn't worried about the money, she never had to worry about money, and now she is all pissed off about the money and that she is a liar and that she will fuck any black guy. She's always kissing on the bus drivers all the time at the Greyhound station. He tells Hoolihan that he would take a polygraph whenHoolihan asked him and he wanted Donna take one too. He says she is a psycho type of woman and one other thing that he said was that she was a fast driver. That she drives like a "bat out of hell." (Maybe she was just pissed?) DetectiveHoolihan asked Santiago, "Why would Donna file this report on you?" He says, "Because of the sex." He wouldn't give it to her. Santiago called Robert Fingerhut at the Youngstown Greyhound and tells him about everything, that he's had an affair with her and she is accusing him of stealing this gun and money. Fingerhut asks him, "How do you know her?" He says, "From the Greyhound station in Warren." He just says, "Oh, okay." And hangs up the phone.

Early on she told him that she would love to have a three some with two black guys, how it would be great to be sucking on one black guy and have the other black guy in her ass.

His friend's name that he spends every evening with Wali, one of the witnesses at Vista Windows, his last name isAkram. I don't know where he lives or anything.

I guess that's it.

HOWLAND POLICE DEPARTMENT

169 Niles Cortland Road NE, Warren, Ohio 44484

SUPPLEMENTAL REPORT

Report #: 01-078868
Date: 12-12-01
Investigator: Det. Sgt. Monroe
Page 1 of 5

On Wednesday, December 12, 2001 at 1:00pm Donna Roberts came to the Howland Police Department with her brother Ralph Roberts and sister in law Rita Roberts. Donna came into the Detective Bureau Conference Room along with Capt. Compton, Det. Sgt. Dillon and R/O. Ralph and Michael Roberts, Donna's brothers waited in the lobby of the police station.

Donna told officers she last saw Robert Fingerhut alive at 8:00am on 12-11-01 in the master bedroom of their 254 Fonderlac SE residence. Robert was getting ready for work and Donna was lying awake in bed. Donna thought Robert went to work at the Warren Greyhound terminal. Donna said she also helps out at the Warren terminal but never the Youngstown office. She sells tickets in Warren and does basic office work. She told officers she doesn't work in the Youngstown office because everything is computerized and she does not know how to use the equipment.

Donna met Robert in Miami, Florida and married August 22, 1983. Robert was a licensed private investigator in Florida. He had a permit to carry a gun there. Robert bought a BCI badge in Miramar, Florida. Donna worked for Dr. Morton Freiman MD a plastic surgeon in North Miami Beach, Florida. Donna told officers she was the office manager and as part of her duties she conducted billing, kept, wrote and maintained medical records. Donna further told officers she was Dr. Freiman's only employee and also served as his medical assistant during surgical procedures. Donna also traveled to Israel with Freiman and did trauma work with him during two wars on fresh battle injured soldiers in the field. Donna said she provided treatment for gunshot wounds and performed skin graphs.

Donna was born in Youngstown, Ohio and married three times. Her first marriage was to William Raymond and lasted six years. The second marriage was to Bert Gelfand for ten years and then to Robert Fingerhut in 1983 for three years. Donna said the only reason her and Robert were divorced was because of financial benefits in the case of a civil suit against Robert. Donna told officers the divorce was Roberts idea. He wanted to put all of their assets in Donna's name so they would be protected in the case of a lawsuit or failure of their business.

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Donna told officers her and Robert got along great and had no real problems with their relationship. They had small problems like any couple. She stated they argued over little things like changing the dog's water, but nothing major. They purchased their 254 Fonderlac residence in 1995. Donna also mentioned Robert was a collector of sports memorable and World War II relics. Donna bought Robert a Cleveland Browns, Brian Sipe field worn football jersey in the early eighties and that is how he got started collecting jerseys, making jerseys and collecting other memorabilia.

Donna told R/O on the day of Robert's murder she woke up around 8:00am when Robert was leaving for work. Donna said she just stayed in bed relaxing until 9:30 or 10:00am. She got out of bed, washed her hair, did her makeup and took care of the girls, "her dogs". At 12:30 she arrived at the Warren Greyhound Bus Terminal and worked until 5:15pm. When Donna arrived Robert had already left the terminal and Donna did not know where he was. Donna said she called Mr. Daniels at the Youngstown terminal to see if Robert was there. She was told Robert had not yet arrived. During her worked period Donna said everything was normal and nothing unusual happened. She said she spent the day alone in the office.

After work Donna went to Giant Eagle and purchased a cooked roast chicken for her dogs to eat. She arrived at 254 Fonderlac SE at 5:45pm and Robert was not there. Robert usually worked in the Youngstown terminal from 2:30pm until the last bus at 9:00pm. Donna called Robert once at the Youngstown terminal after coming home from work. Robert called Donna a couple of times between 5:45 and 9:00pm. Robert called to see what Donna was doing, ask what was for diner and to tell her things were slow at the office.

At 9:00pm, Donna said she called Robert at the Youngstown terminal, he told her he was going to be a little late, but did not say why. Robert told Donna she should go shopping at the mall and buy herself something nice, because she deserved it. Donna said she did not go to the mall, but to Wal-Mart instead.

Donna then said," there is something you don't know about Robert, and you can't let this get back to anyone because no one knows. Robert goes both ways." Donna has never met any of Robert's male friends, but she knows Robert met one of them at the Avalon Inn sometime last year. He has a friend named Bobbie who would call him at the house until last week. Bobbie would call a couple times a week and ask for Robert. Donna said, "Robert has his friends and I have mine, I guess we are just a pretty cool couple".

Donna said, customers have threatened Robert at the bus terminal in Youngstown. Some of the customers are crazy. Donna had no specific details as to who may have made the threats or who the crazy customers were, just that there were a lot of people like that.

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Donna told officers Robert has several firearms, a big rifle with a bayonet, 38-caliber Taurus revolver with a short barrel, 38-caliber revolver with an unexposed hammer, unknown brand and a Smith and Wesson 38 caliber revolver.

On November 20, 2001, the Smith and Wesson 38 caliber revolver was stolen from Donna's car while parked at the Dairy Mart on Logan and East Market St. in Warren, Ohio. Donna said, she helped this guy she really didn't know and gave him a ride. She knows him only as Santiago, who is a black male subject. Donna gave him a ride and he stole the gun and $320.00 Greyhound deposit, which was in the car. Donna said, she ran into the store to buy cigarettes and when she returned to the car, Santiago, the gun and money were all gone. Donna immediately reported this theft to the Warren City Police Department.

Donna told officers six months to a year ago she was dating a guy named Carlos. Donna dated Carlos for two or three months, but she cannot remember his last name. Carlos is a male, half black and half Hispanic of average height and weight. Donna met Carlos at the bus terminal in Warren. Donna's relationship with Carlos was for sex and she had no emotional attachment to him. R/O asked Donna if there was anyone else she had any type of relationships with and she said, "no".

R/O asked Donna if she knew Nate Jackson and she said, "oh yea, I forgot about him. He calls me from prison and he just got out on Sunday, 12-09-01". Donna told officers she went to Lorain and picked Nate Jackson up Sunday when he was released from prison. She has known Jackson for two years and seeing him on a regular basis since they met. They met at the Youngstown bus terminal. Donna told officers Jackson was in prison for being a passenger in a stolen car. Donna also told officers Nate has been in and out of jail for stupid little thing, nothing bad. Donna told officers Robert and Nate were friends. When Donna and Nate got back into Youngstown from Lorain on Sunday, 12-09-01 she dropped Nate off at Shelia and Oscars. Their house is somewhere in Youngstown with red shingles on the side of it, instead of siding. Donna didn't talk to Nate again until Tuesday morning, 12-11-01 on the telephone. Nate called Donna, she did not know where he called from, he just called to say hello. Donna did not see Nate on Tuesday, December 11, 2001.

Donna said, "Nate was not jealous of Robert and Robert understood about Nate. Robert knew all about my relationship with Nate". Donna told officers her and Robert had an understanding and out of respect for Robert she would not bring men to their home to have sex. The last time Nate Jackson was at the 254 Fonderlac with Donna was the weekend before Labor Day. Nate was serving time at CCA in Youngstown and was on a weekend pass. During this visit by Nate, Donna said Robert was home and she did not have sex with Jackson. Over Labor Day weekend, Nate was on a pass from CCA and she had sexual relations with him, but not in the house. Donna said, "her relationships were just a game and the game had only one rule. You don't say I love you to whoever you're dating and Robert was very strict about that".

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Donna told officers the music she likes to listen to is older stuff and pop. Nate likes listening to rap and rhythm and blues. Donna said she stopped at the house on Sunday, 12-09-01 with Nate. She said they were both in the house from 1:00pm to 2:00pm, feed her dogs and picked up some pot, "marijuanna". Nate last spoke with Donna in the morning on the eleventh of December 2001, from a payphone somewhere in Youngstown.

Donna describes Nate as 5'10", thin but with a muscular build, short black hair with dark skin. Donna told officers her and Nate wrote each other a lot. They wrote each other about three times a week. On Thursday and Saturday Nate would call Donna collect from prison.

Donna told officers Robert was a very hyper person and when he got mad he was flaky. About a week, week and a half before Robert's death he was acting kind of nutty up until yesterday. Robert was missing Tuesday, from 11:30am to 2:15pm when he showed up at the Youngstown Terminal for work. Donna said this is out of character for Robert to go or do something without her knowing about it. Robert kept a gun in the center console of his car or tucked between the seat and the console.

Donna went back over what she had done late Tuesday evening on the eleventh of December with officers. At 9:00pm she went to Giant Eagle to buy chicken for her dogs, but they did not have any. Donna was in Giant Eagle approximately five minutes. Donna then went to Wal-Mart and shopped for approximately 30 minutes. Donna bought make up and a cigarette lighter. About 10:30 Donna arrived at Super Kmart and made no stops or detours along the way. Donna told officers she was there a long time and just looked around. She likes looking around at Super Kmart. Donna did not buy anything. Donna said she did not see anyone she knew at Super Kmart, but she did talk with a lady who had a cute little boy with her. Donna left Super Kmart at 11:30pm and went straight home. Donna came down her street and pushed the garage door opener. The garage light came on and the overhead door began to close, so she pushed it again. Donna parked the car in the garage and closed the overhead door.

Donna told officers she has a pending lawsuit against a policeman who worked in the Youngstown bus terminal. She thought the officer's name was Bettencougher and he wore a black uniform. Donna said she did not know what police department the officer was from. Donna said the suit is a couple years old and was dismissed by the court. They have file an appeal with the court and she does not know where the case currently stands. Donna said Attorney Steve Chuparkoff, (330) 744-3010 was handling the appeal.

Donna told officers Robert has a life insurance policy worth $250,000.00 with State Farm and she has one worth $50,000.00, their agent is Cathy Thomas. Thomas can be reached at (330) 793-1136. Donna said Robert was going to increase his life

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JANET CLAY STATEMENT TO:
HOWLAND POLICE

Janet lives at [redacted] Youngstown, Ohio. Her date of birth is [redacted] Her Social is [redacted] Her phone number is [redacted]

Janet met Nate on the 10th @ Sheila's house in the afternoon. Just Janet, Sheila and Nate were present.

Donna picked Nate up in her car on the 10th. They came back later that night and Donna & Nate went into the bedroom to smoke crack. This was done in exchange, of course, for crack paid to Shiela. Nate gave Sheila a gram for the room rental at that time.

Janet said she then saw Nate again the next day (11th) when Nate called Sheila looking for someone to 'kick it' with at the Days Inn. He offered Janet crack and money to come to the Days Inn to 'kick it'.

John takes Janet and Sheila to the Days Inn. He leaves Janet there with Nate, and after getting a hit for bringing her, John and Sheila return to Sheila's house. Sheila told Janet to call for a ride back when she was ready.

Janet said that Nate went to the Kings Motel on the 12th and he had another girl there.

Nate calls Sheila to come and get Janet and John does so. He goes in and gets his hit and then takes Sheila and Nate back to Sheila's house. There, at Sheila's they smoke more crack and Janet said they were up all night. Nate was still there in the morning (of the 12th).

Nate told Janet he cut his hand. She said he was very nervous and jittery, pacing back and forth continually looking out the window and peep hole of the door. She said that Nate was smoking a lot of crack (and this really means something coming from her). She approximated over a gram.

Janet said that Nate was staying at Sheila's house.

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On the night he was arrested, (early morning hours of the 20th) Janet said that Nate had been waiting all day for Donna to come pick him up. She never came. Nate was talking to Donna when the police came. Nate was really upset with Donna that she didn't come get him. Donna said she couldn't because she was at her moms and that she couldn't leave her mom because Mom was so upset with everything. Donna never bothered to call Nate and tell him she wasn't coming.

Janet said that Nate and Donna talked to each other numerous times and Nate would always go off to another room to talk to her.

Janet said that even she knew that something happened. She figured Nate just robbed somebody or something.

Janet never saw any gloves, gun or ski mask.

END

HOWLAND POLICE DEPARTMENT

169 Niles Cortland Road NE, Warren, Ohio 44484

SUPPLEMENTAL REPORT

Report #: 01-078868
Date: 12-12-01
Investigator: Det. Sgt. Monroe
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On Tuesday, December 12, 2001, shortly after 0005 hours R/O was contacted by Ptl. Ray who advised he was at 254 Fonderlac SE where a shooting had occurred. Ptl. Ray advised he was at the crime scene and had one dead male white subject lying on the kitchen floor with a handgun near the body. Ptl. Ray believed the subject had been shot in the head. Ptl. Ray requested assistance processing the crime scene and advised he would also contact Det. Sgt. Dillon and the Corners Office. R/O told Ray to secure the scene and not disturb anything until detectives arrived.

At 0035, R/O arrived at 254 Fonderlac SE and spoke with Ptl. Ray and Ptl. Pollcino. Officers advised there was no sign of forced entry into the residence. Ptl. Pollcino walked around the entire exterior of the residence and found nothing unusual. The victim's wife, Donna Roberts, called 911 and reported the incident. Ptl. Ray further advised Roberts was in the master bedroom.

After quickly surveying the scene, R/O told Captain Phillips of the Howland Fire Departments EMS squad there was no need for his personnel to stand by any long. R/O then contacted Trumbull County Sheriffs Detective Tony Leshnack and Warren City Police Detective Daniel Mason and requested their assistance processing and photographing the crime scene. Det. Sgt. Dillon videotaped the scene.

R/O and Ptl. Ray went into the master bedroom and spoke with the victim. She seemed very excited, anxious, curious and inquisitive as to what had happened. R/O told the victim it appears her husband had been shot. She said, "shot, oh my god, someone murdered my Robert". The victim then started screaming, crying and appeared very emotional for several minutes. R/O told the victim she had to be strong and answer a few questions to assist in the investigation. After a couple of minutes Donna composed her self and began answering questions.

Roberts told officers we have a couple of guns in the house, a small silver gun and a second gun Robert keeps in his car, the silver Chrysler 300 which is missing. R/O

EXHIBIT 70

asked Donna where her husband's car was and she said, "I already answered all these questions. Where is Roberts car, someone stole his car".

Donna said her husband does not drink or do any kind of drugs. She told officer, Robert doesn't have any enemies, and everyone loves him. She said that the pot in the kitchen was hers and Robert never smokes it. Donna said, when she drove down the street around midnight, she tried to use the garage door opener from down the street. She noticed when she pressed the opener the light came on in the garage and the overhead garage door began to close, so she pushed it again and the door went back up. She parked on the right side of the garage as usual and got out of the car. She walked around the back of her car and began to enter the house. She noticed the man door from the garage to the house was standing open, her husband was lying on the floor with blood all around him and coming out of his mouth. She went into the house grabbed the portable telephone and called 911. She then thought an intruder might still be in the house so she went out the front door and stood on the front lawn giving information to 911 until the police arrived. R/O asked Donna if the front door was locked and she said it was. Donna said, she had to turn the deadbolt to open and unlock the front door. Further she indicated they rarely ever use the front door.

R/O explained to Donna, the entire house needed to be handled as a crime scene, searched and officers have no idea where or what the perpetrator may have done or where in the house the perpetrator may have gone and there may be evidence somewhere else in the house. Donna told R/O, do what ever you have to do, just find who ever did this. R/O further explained to Donna, it would be necessary to search the entire house for evidence and it would probably take all night. Donna said, "I told you, do what ever you have to do, search the whole place, just find the guy." R/O asked Donna if anything appeared to be missing and she said no. Donna told R/O, I saw blood coming from Robert's mouth, and did someone stab him.

R/O asked Donna to tell officers everything she had done since she woke up Tuesday, morning December 11, 2001. At approximately 8:00am, Donna awoke to Robert getting ready for work and said goodbye to him. Robert left and went to the Warren Greyhound Terminal. She told officers she stayed in bed until around 10:00am, but did not go back to sleep she just lye there relaxing. At 10:00 she got out of bed, washed her hair and got ready for work. She arrived at work around 12:30pm at the Greyhound bus terminal in Warren and stayed there until 5:30pm. Donna said she was driving the red 2000 Chrysler 300m, which was parked, in the garage. Donna said that is her car and Robert has a silver one just like it.

After work Donna said she went to the Red Lobster Restaurant and had a nice diner alone. Donna paid cash for diner but could not remember what she ate. R/O notice a plastic container on the floor of the passenger side of her vehicle with a clear plastic lid. There were crab legs in the container. When asked about the container with the

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crab legs, Donna said, "Oh yes, I remember, I had the king crab legs and an absolute vodka martini". After diner Donna went straight home.

At 9:00pm Robert Fingerhut called Donna from the Youngstown Greyhound Station and told Donna he was going to be late. Donna said," Robert told me I should go shopping at the mall and get myself something nice, because I deserved it". Donna instead went to Giant Eagle to buy chicken for the dogs at 9:00pm. Donna went from her house on Fonderlac to Firestone to Avalon to East Market Street and pulled into the Giant Eagle parking lot from the traffic light. She said the first handicapped parking space was open and she parked there. Donna ran into the store looking for roasted chicken, which they did not have so she left. Donna said she was in the store approximately five minutes. Donna then went to Wal-Mart on Elm Rd. and took the by-pass to get there. She did not stop anywhere else along the way. While at Wal-Mart, Donna purchased make-up and a cigarette lighter. These items were found on the kitchen table of the residence with at receipt for such, dated 12-11-01 at 9:37pm. Donna thought she was at Wal-Mart approximately ten minutes. She then got back on the by-pass and exited on State Route 46/Niles Cortland Rd. and went to Super Kmart. Donna told officers she arrived a Super Kmart shortly before 10:00pm and walked around the store looking at thing, which she often does. Donna said she did not purchase anything she just looked around. Just before midnight Donna left the store and went straight home. That is when Donna found Robert lying on the floor in the kitchen and called the police. Donna then started.screaming, "Oh my god my Roberts gone, Oh my god my Roberts gone". Donna also told R/O she was seeing Dr. Ariza for postmenopausal depression.

Officers noticed while processing the scene, Donna would start screaming and murmuring loudly when officers were not talking. When officers would begin talking about findings at the scene, Donna would become very quiet, as if she was listening to officers. At one point Sgt. Dillon walked toward the bedroom from the dining room and found Donna standing in the bedroom doorway leaning against the doorframe listening to officers. R/O spoke with Donna and suggested a family member be called to come sit with her and possible take her to another location for the night. Donna provided her brother Ralph Roberts's telephone number to Ptl. Ray.

Donna's brother, Ralph Roberts was contacted by the Austintown Police Department and asked to come to the scene at the request of HPD. Donna spoke with Ralph and decided to leave with her brother and sister in-law Rita Roberts. Donna asked R/O what are you going to do now. R/O told Donna, officers are going to continue processing the crime scene and search for more evidence. Donna said, "Ok you do what ever you have to do". R/O again told Donna officers would need to spend most of the night processing the house and it would be best if she left with her

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brother for support. R/O also told Donna officers would need to speak with her later in the day to further discus the investigation. Donna told R/O to contact her anytime at Ralph's. Ralph Roberts provided R/O, his address, [redacted], Ohio, telephone number [redacted] and told R/O to call if anything was needed. Ralph told R/O, Donna could stay with him as long as needed. Ralph also gave R/O his and Donna's parent's address and telephone number, Mike and Pauline Roberts of [redacted].

While conducting the crime scene inventory the telephone rang. At 3:38am R/O answered the portable telephone, which was upon the dining room table. R/O said hello several time and the caller hung up. R/O entered *57 and *69, causing a telephone trace of the call to be done by the telephone company. When R/O entered *69 an electronic transmission indicated the previous telephone call came from (330) 506-0373. At 3:48am, R/O called said telephone number and whoever answered the telephone immediately hung the telephone up without saying anything.
R/O observed two life insurance polices on Robert Fingerhut, both together inside a cabinet on the upper left side of the master bedroom headboard. These two policies were on top of all the other documents in the cabinet. One of the life insurance policies was with State Farm Insurance valued at $300,000.00; the effective date was from 08-12-99, policy number [redacted] agent Cathy Thomas, (330) 793-1136. The other was with New York Life and it was also a life insurance policy valued at $25,000.00, effective 02-12-01, policy number [redacted], telephone number 1 (800) 695-5164.

R/O conducted the inventory at the crime scene and cataloged the items removed. R/O also administered a gunshot residue test on Donna Roberts before she left the residence. Det. Sgt. Dillon noticed what appeared to be a small amount of blood on Donna's shirt. Donna told R/O she never touched anything at the house nor did she touch Robert. R/O asked Donna if she could change her shirt and allow officers to look at the yellow shirt she was wearing and Donna complied. While at the scene R/O opened the trunk compartment of Donna Roberts's vehicle, Red 2000 Chrysler 300m, Ohio license number [redacted] Inside the trunk R/O found a brown paper bag with the name Nate Jackson and the number 399-469 upon the bag. R/O looked inside the bag and found men's clothing and a second bag containing the items listed on HPD property form as item # 26. Part of item # 26 is 145 hand written letters to Nathaniel Jackson by Donna Roberts.

Those items remained with the all other items secured at the scene. The vehicle was towed by May's Towing to the Trumbull County Sheriffs Department for further processing. Det. Leshnack followed the vehicle in tow and secured it indoors at the Trumbull County Sheriffs evidence-processing garage. Det. Leshnack and Det. Sgt. Pizzulo of the Trumbull County Sheriffs Department later processed the vehicle. At

HOWLAND POLICE DEPARTMENT

169 Niles Cortland Road NE, Warren, Ohio 44484

SUPPLEMENTAL REPORT

Report #: 01-078868
Date: 12-12-01
Investigator: Sgt. Dillon
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0011 Hours – I received a telephone call at my residence from Howland PD Officer Albert E. Ray asking me to respond to 254 Fonderlac Dr. SE in reference to a dead body being discovered in the residence. I told Ptl. Ray that I would be enroute shortly.

0026 Hours – I notified the Trumbull County 911 Dispatch Center that I was enroute to the scene.

0029 Hours – I notified the TC911 that I was on the scene.

Upon my arrival, I spoke with Ptl. Ray who informed me that Donna Roberts had called 911 to inform them that she had returned home and found her husband Robert Fingerhut laying on the kitchen floor. Ptl. Ray told me that he and Ptl. Ron Pollcino arrived on the scene and were met in the front yard by a hysterical Donna Roberts, who came running out the front door of the residence with the phone.

Upon entering the residence, I was informed by Howland Fire Department paramedic George Beck that he had checked the victim's vital signs, he was unable to locate any and that the victim appeared to be expired. I approached the area where the victims body was and noted that the victim was laying face down on the floor to the east of the man doorway that leads from the attached garage into the kitchen. I noted that the victim was laying with his head to the south and his feet to the north. I noted that the victims left arm was raised above his head. I noted that the web of the victim's left hand appeared to have a bleeding wound between his first finger and his thumb. The victim's right arm was resting below his shoulders and was pointing towards his feet. I noted a pool of blood underneath and around the injury to the victim's left hand. I noted a pool of blood underneath and around the victims head and blood drops and smears of blood to the right, (west), of the victims body between his body and the open door. I also noted blood spots north of the victim's feet. A pair of boots rested on the floor above the victims left arm, a green thermos type mug, blood, miscellaneous papers and a case of Pepsi Cola in cans lay between the victims body and the kitchen cabinets and countertops to his east. I noted that a rug at the feet of the victim appeared to have been moved by the victim's feet as he fell to the floor and a case of bottled water was resting to the right

EXHIBIT 71

of his feet. I noted the victim was wearing a red satin Cincinnati Reds medium weight sports jacket, a baseball uniform shirt of some type, (white with red pinstripes), blue jeans, white athletic socks and dirty white high top tennis shoes. The floor to the right, (west), of the victim's torso had scattered blood pooling in many different spots. I noted just outside the door, (on a step in the garage), lay a stainless steel handgun with brown wooden grips. The weapon was lying near the southwest edge of the step, pointing north. There was blood on the step and what appeared to be a partial footprint in the blood near the gun. I noted blood on the kitchen cupboard to the left of the victims body, (on the eastside), below the kitchen counter. Blood was on the wall to the left of the victim's head and the kitchen cabinets below the countertop, (in the southeast corner). There was blood both in the southeast portion of the cupboard below the counter as well as from the southeast corner to the northeast corner. I noted blood just north of the victim's feet on the kitchen floor also.

The victims wife, Donna Roberts told us that the victims vehicle was missing from the garage. I asked Donna if she had any idea who may have the vehicle and she stated she didn't. TC911 was notified and a BOLO was put out on the LEADS/NCIC computer system listing the vehicle as stolen. I asked Donna Roberts if the man door from the garage into the kitchen was routinely kept locked or if it was kept unlocked. Donna Roberts told me that she and the victim kept the door unlocked because they had the electric garage door opener on the overhead door of the garage and that made it very secure. I asked Donna Roberts to calm down long enough to tell me briefly what had happened this evening. Donna began to talk, then suddenly stated, "I can't take this, everywhere I look, everything I see, is Robert laying there on the floor, with all that blood!" I calmed Donna down and again asked what happened tonight. Donna eventually calmed down enough to tell me that she had talked with Robert earlier this evening on the telephone several times, the last time she said she thought it was on his cellular phone. Donna told me that Robert told her that he was going to be a little late and that she should go out shopping since he knew she loved to shop. Donna told me that as a result of her conversation with Robert she left the house and went to Giant Eagle on E. Market St., Wal-Mart on Elm Rd. and Super Kmart on SR46. Donna told me that she didn't buy anything at Giant Eagle or Super Kmart, but she did buy something at Wal-Mart and the bag was on the kitchen table. Donna told me that when she came home, she turned down her street and as she approached her house, she hit the button to open the overhead garage door. Donna told me she was startled because she saw the light come on and the door began to go down. Donna told me that she thought that was unusual because Robert never left the door standing open when they weren't at home. Donna told me that she pulled into the garage, got out of the car, walked around the back of it and over to the door that leads from the garage and it was standing open. Donna told me that was when she saw Robert laying there. Donna then began to shout, Oh My God, Oh My God, I can't believe my Roberts on the floor bleeding, I can't get that picture out of my head!" I gave Donna

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some time to calm down again and asked her what she did when she saw Robert. Donna told me that she, "freaked out," ran into the kitchen and grabbed the portable phone, ran into the bedroom and called 9-1-1. Donna told me that then she realized that someone may still be in the house, so she ran out the front door while on the phone and the police arrived about that time. I asked Donna if she saw anybody near the house or on the property when she was coming down the street and she said no.

As we waited for the arrival of the coroner's office, Ptl. Pollcino and I began checking the interior of the residence for any evidence that someone else may still be in the house as well as any evidence that items may have been taken from the house. Ptl. Pollcino and I checked the entire interior of the residence, no one was located and nothing appeared to be missing from our point of view, (no obvious things such as TV's, VCR's, Stereo Components, Computer Equipment, etc.). However, we did find what appeared to be a droplet of blood on the ceramic tile floor in the hallway that led from the front door to the master bedroom. The droplet was later swabbed by Det. Leshnack and entered into evidence, since it was the only sign of blood evidence in the residence other than the area where the victims was found. After an interior check, I exited the residence and made a complete check of the exterior of the residence for any signs of forced entry, with negative results. Inside the residence itself, I found damage to the main bathroom door near the doorknob. I was unable to locate any signs of damage to any of the exterior man doors or windows. Upon checking the interior of the garage, I noted a metal support bar that ran along the entire inside of the bottom of the overhead door panel was damaged, it appeared to have been partially detached from the door itself and the parts were laying on the garage floor. While checking the exterior of the residence, I noted what appeared to be vehicle tire tracks in the front yard on the north side of the driveway in the northeast corner of the lawn. I also detected slight rubber tire marks on the roadway that appeared to travel south on Fonderlac SE, from the marks on the lawn.

A short time later Trumbull County Forensic Pathologist Dr. Humphrey Germaniuk arrived and began his investigation of the scene. Upon the arrival of Dr. Germaniuk, Shelley Mazanetz of the coroner's office also arrived to assist. At the direction of Howland PD Det. Sgt. Paul Monroe, I began to videotape the area around the body. Upon the arrival of Det. Anthony Leshnack of the Trumbull County Sheriff's Office, photos of the entire residence began.

While conducting our investigation inside the residence, Donna Roberts could be repeatedly heard screaming hysterically, "Oh My God, has Robert been stabbed in the face, Oh My God, why isn't he moving, I can't believe I came home to find my Robert like this," from the master bedroom. At the same time, I noted that Donna would stop shouting hysterically and then become quiet. On one occasion when Donna Roberts stopped screaming, I walked back toward the bedroom from the

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dining room and found Donna standing in the bedroom doorway leaning against the door frame listening attentively to any and all conversations the officers on the scene were saying. I startled Donna Roberts and when she noticed me in the hallway, she began to break down again, screaming, "Why isn't my Robert moving, I can't believe that I saw him that way!" I remained in the master bedroom with Donna Roberts while Det. Sgt. Monroe entered and conducted gun shot residue tests on Donna Roberts hands. While in the room, we noticed what appeared to be bloodstains on the front of the shirt Donna Roberts was wearing near the bottom. The shirt was also collected and entered into evidence. Upon my initial entrance into the residence, I noticed a tray on the dining room table with stems and seeds that appeared to be marijuana as well as matches, cigarette rolling machines, cigarette rolling papers, 2 empty plastic sandwich size baggies and several small pipes that are commonly used to smoke marijuana and crack cocaine. Det Sgt. Monroe and I asked Donna if the drug paraphernalia was the victims and she replied that it was not and insisted that it was hers.

I began checking the entire residence for prescription medication that belonged to the victim as well as Donna Roberts and collected a very large inventory list of medication throughout the residence. Donna Roberts informed me that the victim was taking medication for allergies and high cholesterol.

From that time on, I assisted Dr. Germaniuk, Det. Leshnack and Det. Sgt. Monroe with the collection of evidence. Upon the inspection of the handgun on the step outside the man door by Det. Leshnack, it was learned that the weapon was loaded with five live rounds and no spent rounds.

At approximately 0150 hours, Donna Roberts brother Ralph Roberts and his wife Rita Roberts arrived on the scene to assist Donna in her time of need. Det. Sgt. Monroe asked Mr. Roberts if it was possible for him to take Donna to his residence for the night to get her away from the graphic scene at the residence as well as to provide her with the emotional support she would need at this time. Mr. Roberts told Det. Sgt. Monroe that he would take Donna home. I was standing in the dining room of the residence at the time of Mr. Roberts and his wife's arrival. Prior to Donna Roberts leaving the residence and while in the hallway between the master bedroom and the front door, Det. Sgt. Monroe explained to Donna, Ralph and Rita Roberts that it was best that she leave the house because we, (the police), were going to be there for some time and the entire residence would have to be checked for any evidence of this crime. Det. Sgt. Monroe stated to Donna Roberts, "We are going to have to go through the entire house and check everything Donna." I noted Donna's response to Det. Sgt. Monroe to be, "You do whatever you have to do, I don't care." Donna Roberts then began to explain to her brother Ralph for the second time that her Robert was just laying there and wouldn't move and that it looked like someone stabbed him in the face. Dr. Germaniuk began his inspection of the victim's body by rolling him over. Upon my initial look at the front of the victim's body, I noted his

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face was covered in blood and snot was evident from his nose. I noted the right side of the victim's face and back of his head were swollen and out of proportion. Dr. Germaniuk inspected the victim's head and found a wound on the back near the top. As Dr. Germaniuk began removing the victims clothing, he discovered a bullet inside the layers of three shirts the victim was wearing, as well as bullet holes in his clothing and jacket. I noted that when all the victims shirts were removed, he had a wound on the back of his right upper arm along with what Dr. Germaniuk described as a graze wound on his back near the top to the right of the center of his back. Ptl. Pollcino then found a hole in the ceiling of the basement stairway, (which was directly across the kitchen), (directly north), of the man door from the garage into the house. Another bullet was later recovered from inside that ceiling above the basement stairs.

Eventually during the investigation of the interior portion of the crime scene, Donna Roberts car was removed from the garage. Once it was moved, we discovered a pair of glasses with brown plastic frames as well as a lens from the glasses lying on the floor. I videotaped the glasses where they lay as well as the lens, the damaged rail on the interior of the overhead garage door and the parts from it that were on the garage floor.

0627 Hours – I cleared the scene of the crime. Report on file, investigation to continue.

Signature: [signature] Date: 12-12-01

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HOWLAND POLICE DEPARTMENT

169 Niles Cortland Road NE, Warren, Ohio 44484

SUPPLEMENTAL REPORT

Report #: 01-078868
Date: 12-12-01
Investigator: Sgt. Dillon
Page 1 of 2

The following is a list of prescription medications found in the residence that were written in the name of the victim Robert S. Fingerhut:

In a Kitchen Cabinet
1) Naproxen - 500mgFull 3-28-00
2) Naproxen - 500mgFull 2-16-00

Main Bathroom Cabinet
1) Naproxen - 500mgFull Dr, Benjamin Kulper
2) Sonata - 10mg 8-25-01
3) Alprazolam - 1mg 12-01-01
4) Diazepam - 5mg 5-04-01
5) SodSulfacet - 10% OPSOL 12-05-97
6) Allegra D - 60 120ER Tab

Master Bedroom Cabinet on the Headboard of the Bed
1) Allegra - 60mg 10-22-01
2) Lipitor - 10mg 12-01-01
3) Metroprolol - 50mg 11-17-01
4) Metroprolol - 50mg 10-28-01
5) Lorazepam - 2mg 6-14-01
6) Lipitor - 10mg 11-03-01
7) Allegra - 60mg 11-05-01
8) Metroprolol - 50mg 12-13-98
9) Allegra - 60mg 12-14-98

Per Donna M. Roberts, Mr. Fingerhut was a non-smoker.

EXHIBIT 72

COPY

The following is a list of prescription medications found in the residence that were written in the name of the victims wife, Donna M. Roberts:

In a Kitchen Cabinet

1) Hydroxyn Pam - 50mg 5-26-00 Full
2) Ibuprofen - 600mg 11-15-99
3) Hydroxyn Pam - 50mg 5-12-00
4) Skelaxin - 400mg 7-26-99
5) Risperdal - 2mg 3-01-01
6) Premarin - 0.9mg 4-28-01
7) Hydroxyz - 25mg 2-25-00
8) Hydroxyz - 50mg 6-08-01
9) Paxil - 20mg 12-09-00
10) Medroxyp AC - 10mg 1-04-01
11) Depakote - 250mg 11-09-00
12) Hydroxyn Pam - 50mg 6-03-00
13) Wellbutrin SR - 100mg 6-08-01
14) Meclizine - 12.5mg 9-12-99
15) Despramine - 25mg 6-25-99
16) Paxil - 10mg 2-03-01
17) Xenical - 120mg 8-31-00
18) Correctol/Laxative Tablets

Front Living room Table

1) Depakote - 250mg 10-21-01
2) Wellbetrin SR - 150mg 11-13-01
3) Wellbetrin SR - 150mg 12-03-01
4) Hydroxyn Pam - 50mg 12-03-01
5) Hydroxyn Pam - 50mg 11-13-01

Donna M. Roberts told me that she was a smoker and smoked Newport brand cigarettes.

Signature: _____ Date: 12-12-01

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(1)

MONROE:

ASK FOR LIST OF EFFECTS FOUND ON RSF:

BESIDES $300 IN CASH

A $3500 GOLD BRACELET WITH DIAMOND INITIALS DMR BOUGHT IT AS A WEDDING GIFT 1983

A $1200 WATCH (DMR BOUGHT FOR HIM AS A GIFT)

A SOLID GOLD STAR OF DAVID CHARM

5 OR 6 GOLD CHAINS - BIG + THICK

3 OR 4 OTHER CHARMS - SOLID GOLD

LAW NOT HERE

MONROE HAD 10 DAYS TO ESTABLISH OWNERSHIP OF AUTOMOBILE AND HOUSE - HE DID NOT. I ASKED HIM HOW COULD I STEAL MY OWN PROPERTY. HE DIDN'T CARE.

HE WAS SO HAPHAZARD AND JUDGEMENTAL THAT AS SOON AS HE READ EXAGGERATED 'PRISON TALK' HE WANTED IT TO BE CAPITAL MURDER - A BIG CASE FOR HIM TO MA A NAME FOR HIMSELF - BE IN THE MEDIA.

EXHIBIT 73

10 DAYS. ISN'T THIS A CASE OF A "RUSH TO JUDGEMENT? A WHITE WOMAN + A BLACK MAN - YOUN A WHITE MAN IS DEAD. HE WAS RELENTLESS.

BY CHARGING DMR + NEJ WITH A CAPITAL MURDER - HE KNEW THERE WOULD BE NO BONDING OUT. WE SIT HERE NOW FOR ALMOST 11 MONTHS. AS A RESULT - DMR LOST A HOME, 2 CARS, 2 BUSINESSES, 2 APT. BLDG. A HOUSE FULL OF FURNISHINGS AND 2 10 YEAR OLD MOMMIES LITTLE GIRLS - FLUFFY + BLOSAM.

ADULTERY IS NOT MURDER

BECAUSE MONROE WANTED DRAMA - HE THOUGHT THE 'PRISON TALK' LETTERS + CONVERSATIONS WERE 100% TRUE.

THEREFORE, HE WENT TO DMR HOUSE ALMOST DAILY TO LOOK FOR NATE. HE HAS TAPES OF CONVERSATIONS OF NEJ + DMR THAT HE GOT IN THE BEDROOM WHERE HE INSTALLED HIS TAPE MACHINE. WHERE ARE THESE TAPES ??? CONVENIENTLY MISSING? 3 TIMES HE SENT THE SWAT TEAM WITH DOGS IN TO ~~ARREST~~ ARREST DMR THINKING IN HIS MELODRAMATIC MIND THAT THERE WOULD BE A GOOD OLE WESTERN SHOOT OUT.

WHEN DMR CAME OUT FROM HER GARAGE AND 3 CARS FOLLOWED HER, STOPPED HER ON THE HIGHWAY SCARED THE DAYLIGHTS OUT OF HER PULLING HER TO "CHECK THE TRUNK FOR NEJ!" HONEST.

MONROE WENT TO TCJ ON THE FIRST DAY OF DMR INCARCERATION. TO GET A DNA SAMPLE TO COMPARE IT WITH DNA THAT WAS ON CONDOMS IN MOTEL ROOM - JUST TO SHOW HE THOUGHT A WHITE WOMAN + A BLACK MAN WERE TOGETHER MERE DAYS AFTER RSF DEATH. WHY. WHAT DID THIS HAVE TO DO WITH MURDER?

EVERY GUY IN PRISON TALKS TOUGH.

"EVEN THE POLICE SHOULDN'T BELIEVE EVERYTHING THEY READ OR HEAR." (LETTERS & TAPES

P. MONROE :

PRESUMED ALL THE MISINFORMATION AS FACTS.

RUSH TO JUDGEMENT CAUSED JACKSON AND ROBERTS TO BE ARRESTED FOR CAPITAL MURDER - NO BOND - HE NEVER CHECKED OWNERSHIP OF VEHICLES HE SAID WAS STOLEN.

FINGERNUT HAD A $3000 GOLD + DIAMOND BRACELET ON. HIS $1200 WATCH WAS STILL ON HIM. CREDIT CARDS AND CASH.

THEY HAD 10 DAYS TO INVESTIGATE THIS TO BE SURE PROPER CHARGES WERE FILED

AS SOON AS DMR TOLD HIM ABOUT JACKSON — HIS MIND WAS MADE-UP OF NEG GUILT.
HE WENT TO THE HOUSE ALMOST EVERY DAY. HE TAPED CALLS FROM ROBERTS BEDROOM PHONE TO JACKSON. FULL CO-OPERATION.
MR. BACON FOLLOWED ROBERTS ONE DAY WITH OTHER POLICE UNITS - GOT HER OUT + DEMANDED SHE OPEN THE TRUNK ASSUMING JACKSON WAS IN IT

SWAT TEAM TO ARREST ROBERTS THINKING JACKSON

THIS ENTIRE CASE WAS MISHANDLED AT IT'S ONSET. AS SOON AS MONROE (P.M.) ASK DMR IF SHE HAD A BOYFRIEND AND SHE SAID SO IMMEDIATELY - SHE WAS GUILTY IN HIS MIND. CASE OVER. NOW: A CONCLUSION AND LET'S MAKE THE EVIDENCE FIT AROUND IT. TOUGH THUG TALK. TOUGH PRISONER TALK = TAKEN AS THOUGH IT WAS 100% TRUE.

IN 10 DAYS - FROM 12/11 TO 12/21, THE ARREST THAT WAS WHAT THEY WENT BY. IN THEIR EFFORT FOR DRAMA, THEY ADDED BURGLARY AND THEFT SO THAT THE 11 2 LIVING VICTIMS, DMR + NEJ WOULD BE CHARGED WITH CAPITAL MURDER, HENCE, NO BOND, SINCE 12/21/01. THIS IS AN UNFORGIVEABLE ABOMINATION. ONE WOULD PRESUME THAT BEFORE ARRESTING TWO PEOPLE WITH SUCH SEVERE CHARGES, THERE WOULD BE AT LEAST SOME INVESTIGATING TO ESTABLISH OWNERSHIP OF WHAT THEY CALLING STOLEN PROPERTY THUS SECURING THE CAPITAL CHARGES. DMR EVEN ASKED REPEATEDLY - HOW CAN I POSSIBLY STEAL MY OWN PROPERTY? NEJ ALWAYS DROVE THE CARS. HE HAD ETERNAL PERMISSION FROM THE OWNER: DMR. THEY CAUSED NEJ TO BE IMPRISONED FOR ALMOST A YEAR RATHER THAN - HAVING COME OUT OF PRISON CLEAN, NO PAPERS, HE INTENDED TO SECURE EMPLOYMENT AND START A NEW LIFE. DUE TO NO BOND FOR THE 'CAPITAL' CHARGES, DMR LOST HER ~~LAST~~ LIFE! HOMES, 2 BUSINESSES, CARS, COLLECTIONS - SPORTS, DOLLS, JEWELRY, CRYSTAL, 2 APT BLDG., DOGS. WHO WILL ANSWER FOR THIS PAUL MONROE? WHO? GOT ALL THE ANSWERS? HIDING EVIDENCE ARE YOU PAUL?

Trumbull County
Sheriff's Office
Investigative Division
Det. Sgt. Peter J. Pizzulo
Administration (330) 675-2540
Desk / voice mail (330) 675-2506
Pager (330) 675-0988
Fax (330) 675-7012

Lab Report

Case# Common Pleas 01-CR-784
From: Det. Sgt. Peter J. Pizzulo
CC: file, Howland PD, TCSO
Date: Wednesday, May 01, 2002
Re: Nathaniel E. Jackson , Judgement Entry Order

On 24 April 02 Judge Stuard issued an order for Handwriting Exemplars to be taken from Nathaniel Jackson. Mr. Jackson's Council Anthony Consoldane agreed that this would be done on 29 April in Judge Stuard's Jury room.

Investigators met with Attorney Consoldane at 1230 on 29 April and after some discussion with Judge Stuard, it was acceptable that the Exemplars be done in an interview room of the TCSO Jail. Originally Mr. Jackson was to re-write a 4 page letter three times for submission to BCI&I. After some conversation between Attorney Consoldane and Prosecutor Watkins it was acceptable for him to re-write the first and last pages only along with addressing an envelope thee times.

At approx. 1250 on 29 April with Attorney Consoldane present Mr. Jackson was given the sample pages and asked to re-write them.

At 1320, Hrs Mr. Jackson stated that he did not want to continue due to the discomfort he was experiencing in his hand. (NOTE) Due to an injury that Mr. Jackson had incurred at the time of the alleged offence he can not use is index finger when holding a pen or pencil.

It was agreed by Attorney Consoldane that we would continue on 30 April 02 at 1100 hrs. The Exemplar that was completed so far was sealed in an envelope with Attorney Consoldane Witnessing.

30 April 2002, 1100 hrs Det. Sgt. Monroe and Contacted Mr. Jackson about continuing the Exemplar, he stated that he will no longer comply with the request and that he has contacted the Public Defenders office with his decision. Attorney Consoldane was made aware of Mr. Jackson's unwillingness to continue. County Prosecutors office was made aware of the status.

EXHIBIT 75

01 May 2002, I spoke with Attorney Conscidane via telephone.

Attorney Consoldane indicated that he spoke with Nathaniel Jackson about his unwillingness to continue with the Exemplars and confirms that Mr. Jackson will not be providing further handwriting samples at this time.

The Exemplar that was obtained on 29 April was turned over to Det SGT Monroe for transport to 2C121.

DET SGT Peter J. Pizzulo, TCSO

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PROPOSITION OF LAW NO. 2

THE DEFENDANT'S RIGHT TO THE EFFECTIVE ASSISTANCE OF COUNSEL IS VIOLATED WHEN COUNSEL'S PERFORMANCE IS DEFICIENT TO THE DEFENDANT'S PREJUDICE. U.S. CONSTITUTION, AMENDMENT VI; OHIO CONSTITUTION, ARTICLE I, SECTION 10.

The Sixth Amendment right to counsel applies to the states through the Fourteenth Amendment. Gideon v. Wainright (1963), 372 U.S. 335. The test for whether that right has been violated is found in Strickland v. Washington (1984), 466 U.S. 668, which obliges reviewing courts to determine if counsel's performance is deficient. Id. at 687. If counsel's performance is deficient, the reviewing court must determine if the accused was thereby prejudiced. Id. In order to establish prejudice, the accused need not establish outcome determinative error. Id. at 693-694. State v. Clifton (1999), 85 Ohio St. 3d 433, 450. Instead, the accused is prejudiced when the reviewing court loses confidence in the fairness of the trial. Id.

Strategic choices by appointed counsel are virtually unassailable. Id. at 690. Strickland makes clear, however, that a reasonable investigation of both the facts and the applicable law is required before counsel's choice may be deemed strategic. Id. At 691. Furthermore, Strickland requires that appointed counsel in a criminal case meet a "duty to advocate the defendant's cause . . . [and] . . . bring to bear such skill and knowledge as will render the trial a reliable testing process." Id. At 688. Federal courts have consistently recognized that Strickland's duties to advocate and to employ "skill and knowledge" include the necessity for trial counsel to object or otherwise preserve federal issues for review.

Gravely v. Mills (6th Cir. 1996), 87 F.3d 779; State v. Lockhart (8th Cir. 1994), 23 F.3d 1280;

Argument: Nathaniel Jackson's Sixth Amendment right to counsel was violated by defense counsel's prejudicially deficient performance at both phases of this capital case.

Defense counsel failed to object to the prosecution's extraction of guilty verdict and death verdict promises from all twelve impaneled jury members during the voir dire phase of the trial.

It is improper in voir dire to extract promises from a jury. State v. Powers (10th App. Dist.), 1992 Ohio App. LEXIS 1009; State v. Treesh (11th App. Dist.), 1998 Ohio App. LEXIS 4886; State v. Treesh (2001), 90 Ohio St. 3d 460.

In the instant cause, the prosecuting attorney extracted promises from all twelve impaneled jurors that each would render a finding of guilty in the trial phase of the case if the State proved all elements of its case by proof beyond a reasonable doubt, and that each would render a verdict of death if the state in the penalty phase proved beyond a reasonable doubt that the aggravating circumstances in the case outweighed any mitigating factors which the defendant might offer. (TR- 686-87, 936, 952, 955, 1044, 1163, 1165, 1260, 1289, 1316, 1346, 1389, 1400, 1494, 1502).

In general, the purpose of voir dire of a prospective juror is to determine whether he has both the statutory qualification of a juror and is free from bias or prejudice for or against either litigant. Pavilonis v. Valentine (1929), 120 Ohio St. 154, 165 N.E. 730, paragraph one of the syllabus. The primary purpose of voir dire examination in a capital murder case is to determine whether a juror will truly consider aggravating circumstances and mitigating factors in determining appropriate penalty and not ultimately vote to impose the death

penalty merely because a murder has been committed. See Morgan v. Illinois (1992), 504 U.S. 719, 119 L. Ed. 2d 492, 112 S. Ct. 2222. The purpose of voir dire is not to prejudice a jury and predispose its verdict or viewpoint prior to the offer and consideration of evidence.

In State v. Treesh, supra, at 465, this court held that notwithstanding the timely objection by defense counsel to the prosecutor's extraction of promises for a guilty verdict, and counsel's argument that said conduct constituted constitutional misconduct which created a biased and partial jury, that Treesh "ha[d] failed to demonstrate how the question affected a substantial right." Id. at 465. In the case sub judice, defense counsel failed to object to any of the extracted promises from the twelve jurors impaneled who ultimately found defendant guilty and recommended a sentence of death. Although this court has previously held that "'the failure to object to error, alone, is not enough to sustain a claim of ineffective assistance of counsel,'" where "appellant does not show that any particular failure to object substantially violated any essential duty or was otherwise prejudicial..." State v. Hanna (2002), 95 Ohio St. 3d 285, citing State v. Holloway (1988), 38 Ohio St. 3d 239 at 244, appellant notes that failure of counsel to object to the prosecutors extracted promises thereby waived review of that conduct except under the doctrine of plain error, State v. Hanna, supra at 308, all of which limits review of ineffective assistance for failure to object under an outcome determinative test. State v. Gross (2002), 97 Ohio St. 3d 121.

Appellant submits that his counsel had a duty to seat a fair and impartial jury and one that was not predisposed to convict and recommend a sentence of death; that counsel failed repeatedly in this duty by allowing the prosecutor to condition and predispose the jury to a guilty and death sentence mindset; and that the so-called "death qualification" of the jury as

recognized in Witherspoon took on an expanded and new meaning in the instant cause and thereby prejudiced the right of defendant to a fair and impartial trial and the effective assistance of counsel therein, all in violation of his constitutional rights.

Counsel repeatedly failed to object during voir dire to the prosecutor's comments and questions which sought to limit the type of mitigating factors which might justify a sentence other than death.

During voir dire, the prosecutor questioned ten of the twelve impaneled jurors on matters relating to mitigation, limiting his examples of mitigators that might compel a jury to vote for life instead of death to "mental disease or defect" (TR- 826, 923, 959, 1164, 1258) and to youthful "age" (1288, 1314, 1344, 1396, 1500). Notwithstanding that the purported use of these mitigators was to insure that the jury would nonetheless weigh aggravating circumstances against mitigating factors, regardless of their type or variety, the use of just two mitigators by the prosecutor, which he acknowledged as perhaps justifying life, and which he knew were inapplicable to the appellant, nonetheless conditioned and predisposed the jury to await for those mitigators and those mitigators only during the penalty phase. Defense counsel failed routinely and repeatedly to object to this inappropriate trial tactic, which effectively denigrated appellant's mitigation evidence.

In State v. Jones (2001), 91 Ohio St. 3d 335, this court considered the claimed error of appellant who argued that he should have been permitted to ask prospective jurors about their views on specific mitigating factors; that the trial court's refusal to permit that line of questioning left several jurors confused as to the meaning of mitigation; and that his inability to ask about specific mitigating factors, coupled with juror confusion about the meaning of

mitigation, limited his ability to uncover potential biases in prospective jurors and may have resulted in the empanelling of jurors who were unwilling to consider mitigating evidence.

In rejecting appellant's claim, this court held that "[d]uring voir dire, a trial court is under no obligation to discuss, or to permit the attorneys to discuss, specific mitigating factors, State v. Wilson (1996), 74 Ohio St. 3d 381, 385-386, 659 N.E.2d 292, 300-301; State v. Lundgren (1995), 73 Ohio St. 3d 474, 481, 653 N.E.2d 304, 315, [and that] [r]ealistically, jurors cannot be asked to weigh specific factors until they have heard all the evidence and been fully instructed on the applicable law." State v. Jones, supra, at 338.

In light of Jones, supra, it is clear that the prosecutor in the instant cause was improperly asking jurors to weigh and consider specific mitigating factors during voir dire, all of which he limited for his own purpose, and all without routine objection from appellant's counsel. Again, by failing to object to the prosecutors misconduct, counsel for appellant thereby waived review of that conduct except under the doctrine of plain error, State v. Hanna, supra at 308, all of which limits review of ineffective assistance for failure to object under an outcome determinative test. State v. Gross (2002), 97 Ohio St. 3d 121.

Appellant submits that his counsel had a duty to seat a fair and impartial jury that was open to considering mitigation evidence of any variety and that was not predisposed to convict and recommend a sentence of death; that counsel failed repeatedly in his duty by allowing the prosecutor to condition and predispose the jury to consider only two mitigating factors which were given the imprimatur by the prosecutor of possibly being worthy of a life sentence verdict; and that the failure, inaction and unawareness of his trial counsel to the law

thereby prejudiced the right of appellant to a fair and impartial trial and the effective assistance of counsel therein, all in violation of his constitutional rights.

Defense counsel failed repeatedly to object to inappropriate statements and misconduct of the prosecutor during voir dire that materially prejudiced and predisposed the jury to guilty and death sentence verdicts.

During voir dire, the prosecutor made inappropriate statements to five impaneled jurors, either by mis-stating the law or discussing facts and evidence not alleged in the indictments or proven at trial, all of which prejudiced and predisposed the jurors to guilty and death sentence mindsets, namely, (1) that "[t]he first trial deals with the state proving beyond a reasonable doubt, the defendant committed aggravated murder" (TR- 820); (2) "if you found beyond a reasonable doubt even though there were mitigating factors, you would still, under the law, return a verdict recommending the death penalty, do you understand that?" (TR- 826); (3) "So we're dealing with charges where the person committed the crime, the defendant is alleged of killing a homeowner" (TR- 930); (4) "in this case the aggravating circumstances accuse the defendant of purposely killing a homeowner in the commission of an aggravated burglary" (TR- 1046); (5) "So that means that you would be able, if you were one of the 12 jurors, to listen to the evidence and decide the defendant's guilt based only on the evidence, right?'(TR- 1157); and (6) "In this case, the defendant is charged with killing a homeowner in an aggravated murder" (TR- 1392-1393).

During voir dire, it is improper for counsel to discuss evidence. State v. Johnson (8th App. Dist.), 1997 Ohio App. LEXIS 100. In the instant cause, the prosecutor not only mis-stated the law during voir dire, but also sought on three occasions to repeatedly discuss evidence with jurors ultimately empanelled, that would not be proven, namely, that the

defendant killed a homeowner, a fact that the prosecutor would ultimately acknowledge during trial as wrong (TR- 3383, 3397), only to re-assert the mis-statement of fact and evidence three times during final argument in the penalty phase, namely: that "it was his specific intent to kill the victim, to commit an aggravated murder against a homeowner" (Penalty Phase TR- 142/2-4); that "it can't get any worse than being in prison and planning the execution of a homeowner who just comes home" (Penalty Phase TR- 142/19-21); and that "[i] t is the worst form. The other is that after he kills a homeowner" (Penalty Phase TR- 143/15-16).

Appellant's counsel sat silently during voir dire without objection as the prosecutor mis-stated the law and commented on evidence that would not be proven at trial, and only finally objected to the prosecutor's mis-statement of fact after the prosecutor's third re-statement of the error during final argument in the penalty phase (TR- 143/17-18). By reason of this negligence and inaction, counsel failed repeatedly in their duty to appellant by allowing the prosecutor to appeal to the passion of the jury and thereby predispose it to a guilty and death sentence mindset, thereby prejudicing the right of appellant to a fair and impartial trial and the effective assistance of counsel therein, all in violation of his constitutional rights.

Defense counsel fashioned a defense to death penalty specifications of Aggravated Burglary and Aggravated Robbery under R.C. 2929.04(A)(7) which demonstrated counsel's unawareness of the law relative to the proof and elements of those specifications.

Appellant was convicted on counts one and two of the indictment charging appellant with the aggravated murder of Robert Fingerhut while committing the acts of aggravated

to bear such skill and knowledge as will render the trial a reliable testing process." Id. At 688. It cannot reasonably be argued that counsel met that standard in this cause, given counsel's patent unawareness of the law which only became evident to them after close of the evidence in the trial stage and discussion of jury instructions thereafter with the court and opposing counsel (TR- 3344-3371).

Appellant submits that counsel had a responsibility to provide him a reasonable and legally sound defense to the capital charges brought against him; that they failed in that duty and obligation, and effectively rendered no defense to the capital specifications at the trial phase; and that the failure of counsel in this regard calls into question whether the trial in this matter constituted a reliable testing process causing a reviewing court to lose confidence in the fairness of the trial. *Strickland v. Washington*, supra.

Defense counsel failed to object to the admission into evidence of State's Exhibits 271D-1 to 271D-139, letters from Donna Roberts to Nathaniel Jackson from January 2001 to December 2001, without requiring authentication of writing as a predicate to admission.

During the offer of State's exhibits into evidence, defense counsel allowed admission without objection of 139 letters purportedly written by Donna Roberts to Nathaniel Jackson between January 2001 to December 2001, which were argued by the State to contain information and evidence regarding Donna Roberts and appellant's plan to murder Robert Fingerhut (TR- 2076, 2231, 2294-2302, 3151, 3431-3437).

Unlike the letters from Nathaniel Jackson to Donna Roberts which were admitted into evidence after authentication of the author was established by testimony of a handwriting

analysis expert (TR- 2852-2875), no such authentication was offered for the letters purportedly written by Donna Roberts (TR- 2879). Accordingly, there was no reliable and appropriate predicate for the admission of State's Exhibits 271D-1 to 271D-139. Indeed, the only basis offered for the admission of the letters was through the testimony of Detective Paul Monroe, Howland Police Department, who testified that the letters were recovered from a search of Donna Robert's vehicle and were located in the trunk of her automobile (TR-2294-2295). Given that there was no evidence offered at trial that Donna Roberts admitted authoring the letters that were marked and received as evidence; and given that there was no evidence offered at trial establishing that appellant acknowledged and identified State's Exhibits 271D-1 to 271D-139 as letters he had received from Donna Roberts, the letters purportedly written by Donna Roberts should not have been admitted into evidence.

Because the letters identified by the State as being sent by Donna Roberts to appellant were critical to the State's proof that Donna Roberts and appellant had committed Robert Fingerhut's murder by prior calculation and design, all as set forth in count one of the indictment, for which appellant was convicted and sentenced to death, the admission of said letters through the negligence of defense counsel cannot be considered as a harmless error

Based upon the foregoing, appellant submits that the cumulative effect of the foregoing errors and omissions by trial counsel infringed upon his right to effective assistance of counsel, *Harris v. Wood* (9th Cir. 1995), 64 F. 3d 1432, 1438; that his convictions must be therefore reversed and his case remanded for a new trial; or alternatively, that his death sentence be vacated and his case remanded for re-sentencing.

Attorney General
Betty D. Montgomery

BCI-30 (Rev. 3-95)

Bureau of Criminal Identification and Investigation — Laboratory Report

To: Howland Police Department
169 Niles-Cortland Road, N.E.
Warren, Ohio 44484
Attn: Det. Sgt. Monroe

BCI Lab Number: 01-35755

Analysis Date: 12-14-01

Re: Homicide
Subject: None Listed
Victim: Robert S. Fingerhut

Agency Number: 2001-078868

Submitted 12-14-01 by Det. Sgt. Monroe

1. GSR kit from victim's wife

Findings

Scanning electron microscopy/energy dispersive x-ray spectroscopy analysis was performed on the samples from Donna M. Roberts (item 1).

Gunshot residue was not conclusively identified on the "Left Hand" or Right Hand" samples.

Donna L. Rose
Forensic Scientist

DLR:km
T-7-29-02

EXHIBIT 77

Please address inquiries to the office indicated, using the BCI case number.

[ ] BCI & I-Bowling Green Office
P. O. Box 928
Bowling Green, OH 43402
Phone: (419) 353-5603

[ ] BCI & I-London Office
P. O. Box 365
London, Ohio 43140
Phone: (740) 845-2000

[X] BCI & I-Richfield Office
P. O. Box 336
3333 Brecksville Road
Richfield, Ohio 44286
Phone: (330) 659-4600

[ ] BCI & I-Cambridge Office
60788 Southgate Road
Byesville, Ohio 43723
Phone: (740) 439-3655

IN THE COURT OF COMMON PLEAS
TRUMBULL COUNTY, OHIO

STATE OF OHIO,	:	
Plaintiff,	:	Case No. 01-CR-794
-vs-	:	
NATHANIEL JACKSON,	:	
Defendant	:	

EXHIBIT _____

AFFIDAVIT OF THOMAS ANDREW BOYD, PSY.D.

STATE OF OHIO :
: ss:
COUNTY OF CUYAHOGA :

Dr. Thomas Andrew Boyd, after being duly sworn according to law, states as follows:

1. I am a licensed psychologist in the States of Ohio and Rhode Island (though I am currently inactive in Rhode Island).

2. I have a Bachelor of Science Degree from the University of Massachusetts (I graduated Magna Cum Laude). I have both a Masters of Science Degree and a Doctor of Psychology Degree in Clinical Psychology from Hahnemann University in Philadelphia, Pennsylvania (the program has since relocated to Widener University).

3. I am a diplomate in four areas of psychology, including forensic clinical psychology and forensic neuropsychology.

4. I am the director of Clinical and Forensic Services for Behavior Management Associates, Inc. I have previously held faculty appointments at four universities and staff appointments at seven hospitals.

EXHIBIT
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5. I have attached to this Affidavit a copy of my vitae which is complete and accurate.

6. Dorian Hall of the Office of the Ohio Public Defender retained my services in the above case. Ms. Hall provided me with the following records: a) mitigation testimony of Dr. Sandra McPherson; b) file of Dr. McPherson; c) the report of Dr. McPherson; and d) records from the Neal Kennedy Recovery Clinic, Community Corrections, and Youngstown Alternative School.

7. I reviewed the Wechsler Adult Intelligence Scale – Version ("WAIS-III") and the Wide Range Achievement Test – Version III ("WRAT-III") that Dr. McPherson administered to Nathaniel Jackson on or about March 13, 2002.

8. Dr. McPherson recorded the data from the WAIS-III on a blank sheet of paper, rather than on the full test booklet, as proscribed by the testing protocol.

9. Dr. McPherson reported on the blank sheet of paper and in her formal report the following results for the WAIS-III:

VERBAL SCALE

Subtest	Raw Score	Scaled Score
Vocabulary	18	5
Similarities	11[A]	5
Arithmetic	7	5[B]
Digit Span	20	12
Information	6	5
Comprehension	6	5[C]
Sum of Scaled Scores		42[D]
VERBAL IQ		**82[E]**

PERFORMANCE SCALE

Subtest	Raw Score	Scaled Score
Picture Completion	18	8
Digit Symbol-Coding	56	6
Block Design	29	7
Matrix Reasoning	21	13
Picture Arrangement	15	10
Sum of Scaled Scores		42[F]
PERFORMANCE IQ		**89[G]**

FULL SCALE IQ = 84[H]

10. Dr. McPherson committed eight errors in the computing, recording and reporting of Nathaniel Jackson's scores on the WAIS-III.[1]

A. The raw score for the Similarities subtest should have been 13, not 11, as reported by Dr. McPherson. This errors was not material, because it yielded the same subtest Scaled Score of 5.

B. The raw score of 7 on the Arithmetic subtest translates to a Scaled Score of 4, and not 5, as reported by Dr. McPherson.

C. The raw score of 6 on the Comprehension subtest translates to a Scaled Score of 3, and not 5, as reported by Dr. McPherson.

D. The Sum of Scaled Scores for the Verbal Scale is equal to the total sum of the Scaled Scores for the individual Verbal subtests. Based on Dr. McPherson's reported Scaled Scores this tally should have been 37, and not 42, as reported by Dr. McPherson. However, as a result of the errors identified in Subparagraphs B and C, the actual Sum of Scaled Scores for the Verbal subtests was 34.

E. The revised value for the Verbal IQ was 74, and not 82, as was reported by Dr. McPherson.

F. The Sum of Scaled Scores for the Performance Scale is equal to the total sum of the Scaled Scores for the individual Performance subtests. Dr. McPherson incorrectly added these scores. The actual tally was 44, and not 42, as reported by Dr. McPherson.

G. The revised value for Nathaniel Jackson's Performance IQ was 91, and not 89, as reported by Dr. McPherson.

[1] The following paragraphs refer to the footnoted sections of the previous table.

11. The actual Full Scale IQ for Nathaniel Jackson was 80, as opposed to 84, as reported by Dr. McPherson (at footnote H in the previous table).

12. If the WAIS-III results had been scored and recorded correctly, Dr. McPherson would have reported the results as follows:

VERBAL SCALE		**PERFORMANCE SCALE**	
Subtest	**Scaled Score**	**Subtest**	**Scaled Score**
Vocabulary	5	Picture Completion	8
Similarities	5	Digit Symbol-Coding	6
Arithmetic	4	Block Design	7
Digit Span	12	Matrix Reasoning	13
Information	5	Picture Arrangement	10
Comprehension	3		
VERBAL IQ	**74**	**PERFORMANCE IQ**	**91**

FULL SCALE IQ = 80

13. In her report, Dr. McPherson reported the following results for the WRAT-III that she administered to Nathaniel Jackson:

SUBTEST	**RAW SCORE**	**STANDARD SCORE**	**PERCENTILE**	**GRADE SCORE**	**ABSOLUTE SCORE**
Reading[I]	36[J]	75[K]	5[L]	5[M]	503[N]
Spelling	43[O]	103[P]	58[Q]	High School[R]	524[S]
Arithmetic[I]	46[T]	111[U]	77[V]	High School[W]	532[X]

14. Dr. McPherson committed sixteen errors in the computing, recording and reporting of Nathaniel Jackson's scores on the WRAT-III.[2]

15. On February 11, 2004 I administered to Nathaniel Jackson the WAIS-III. He received a Verbal IQ of 71, a Performance IQ of 83, and a Full Scale IQ of 75.

[2] Identified errors occurred at the footnoted sections in the above WRAT-III table.

Further affiant saith naught.

Thomas A. Boyd, Psy.D.
Licensed Clinical Psychologist

Sworn to and subscribed in my presence this 23rd day of March, 2004.

NOTARY PUBLIC

Noah R. Frient
Notary Public, State of Ohio
My Commission Expires 9/29/07

#194851

CURRICULUM VITAE

2004

THOMAS ANDREW BOYD, Psy.D.
Licensed Clinical Psychologist

PERSONAL INFORMATION

Date of Birth:	[redacted]
Place of Birth:	Malden, Massachusetts
Citizenship:	USA
Social Security #:	[redacted]
Work Address:	Behavior Management Associates, Inc. 23240 Chagrin Boulevard - Suite 500 Beachwood, Ohio 44122-5471
Work Telephone:	(216) 292-6007
Fax:	(216) 292-7352

EDUCATION

1.	**Institution:**	Hahnemann University, Philadelphia, PA (Now Widener University, Chester, PA)
	Year:	1982
	Degree:	Doctor of Psychology (Psy.D.)
	Major:	Clinical Psychology (APA-Approved Program) Clinical Neuropsychology Track
	Dissertation:	Neuropsychological Testing of Patients with Systemic Lupus Erythematosus Chair: Sandra P. Koffler, Ph.D.
2.	**Institution:**	Hahnemann University, Philadelphia, PA
	Year:	1979
	Degree:	Master of Science (APA-Approved Program)
	Major:	Clinical Psychology
3.	**Institution:**	University of Massachusetts, Amherst, MA
	Year:	1975
	Degree:	Bachelor of Science
	Major:	Psychology
	Honors:	Magna Cum Laude

CLINICAL TRAINING

Post-Graduate

1.	**Neuropsychology Associate**	Hahnemann University Hospital, Philadelphia, PA	1983 - 1984

2.	**Post-Doctoral Fellow in Clinical Neuropsychology**	Department of Psychiatry and Human Behavior Division of Biology and Medicine Brown University and Department of Psychology Bradley Hospital (East Providence, RI)	1982 - 1983

Internship

Hahnemann University "Captive" Internship Training Program (APA-Approved)
Integrated with the Doctoral Program in Clinical Psychology
1979 - 1982 (part-time: 3600+ Hours)

Rotations:

1.	**Neuropsychology Laboratory**	Hahnemann University Hospital, Philadelphia, PA	1981 - 1982
2.	**Hay Associates**	Philadelphia, PA	1980 - 1981
3.	**John F. Kennedy CMHC**	Philadelphia, PA	1979 - 1982

Psychology Trainee

Hahnemann University Graduate Program in Clinical Psychology Field Placements 1977 - 1980

Practica:

1.	**Outpatient Psychiatry Clinic**	Jefferson Medical College & Hospital, Philadelphia, PA	1978 - 1980
2.	**Partial Hospitalization Program**	Central Montgomery Community Mental Health Center Norristown, PA	1977 - 1978

PROFESSIONAL LICENSES & CERTIFICATIONS

1.	Licensure in Psychology	# 3893	Ohio	1987 to Present
2.	Certification in Psychology	# PS-277	Rhode Island	1985 - 1987 Currently Inactive
3.	Certified Neuropsychologist		National Academy of Neuropsychology	Certification date 1/1/91
4.	Diplomate Board Certified Forensic Examiner	#8657	American Board of Forensic Examiners	1996 to Present
5.	Fellow	#8657	American College of Forensic Examiners	1999 to Present
6.	Diplomate and Senior Disability Analyst	#4291-97	American Board of Disability Analysts	1997 to Present
7.	Diplomate in Forensic Neuropsychology	#8657	American Board of Psychological Specialties	1997 to Present
8.	Diplomate in Forensic Clinical Psychology	#8657	American Board of Psychological Specialties	1997 to Present

PROFESSIONAL POSITIONS

1. Director of Clinical and Forensic Services — 2002 to Present

   Behavior Management Associates, Inc.
   23240 Chagrin Boulevard, Suite 500
   Beachwood, Ohio 44122-5471

2. Associate — 1995 to 2002

   Behavior Management Associates, Inc.

3. Consulting Psychologist — 1996 to 2003

   Caloh, Inc.
   Statewide Independent Medical Examiners
   Specializing in Occupational/Industrial Medicine
   P.O. Box 1307
   Bath, Ohio 44210-1307

4. Consulting Psychologist — 1997 to 2002

   Managed Medical Assurance Company, LTD
   4150 Belden Village Street, Suite 503
   Canton, Ohio 44718

5. Director, Department of Psychology — 1993 to 1995
   The Rehabilitation Hospital at Heather Hill
   12340 Bass Lake Road
   Chardon, Ohio 44024

6. Director, Psychological Assessment Center (PAC) — 1987 - 1993
   MetroHealth Medical Center (MHMC)
   (Formerly Cleveland Metropolitan General Hospital)
   2500 MetroHealth Drive
   Cleveland, Ohio 44109-1998

7. Chief Psychologist, Children's Inpatient Unit — 1984 - 1987
   Bradley Hospital
   1011 Veterans' Memorial Parkway
   East Providence, Rhode Island

FACULTY POSITIONS

1. Assistant Professor of Psychiatry and Psychology — 1987 to 1998
   Department of Psychiatry
   Case Western Reserve University School of Medicine
   Cleveland, Ohio

   Full-Time Appointment — 1987 - 1993
   Adjunct Appointment — 1993 to 1998

2. Clinical Assistant Professor — 1984 - 1988
   Department of Psychiatry and Human Behavior
   Division of Biology and Medicine
   Brown University
   Providence, Rhode Island

3. Assistant Professor of Psychology in Psychiatry — 1983 - 1984
Department of Mental Health Sciences
Hahnemann University
Philadelphia, PA

4. Assistant Instructor — 1982 - 1983
Department of Psychiatry and Human Behavior
Division of Biology and Medicine
Brown University

5. Instructor — 1977 - 1982
School of Allied Health Professions
Program in Mental Health Technology
Hahnemann University
Philadelphia, PA

6. Lecturer — 1980 - 1982
Department of Speech Pathology
The Graduate School
Hahnemann University
Philadelphia, PA

7. Assistant Instructor — 1972 - 1974
Orchard Hill Residential College
University of Massachusetts
Amherst, MA

HOSPITAL APPOINTMENTS

1.	Member	Psychiatry/Psychology	Aultman Hospital	1997 to 2002
2.	Director	Department of Psychology	Heather Hill, Inc.	1993 to 1995
3.	Member	Medical Staff	Rehabilitation Hospital at Heather Hill	1993 to 1995
4.	Director	Psychological Assessment Center	MetroHealth Medical Center	1987 - 1993
5.	Member	Associate Medical Staff	MetroHealth Medical Center	1994 - 1995
6.	Member	Adjunct Medical Staff	MetroHealth Medical Center	1987 - 1994
7.	Consulting Psychologist	Medical Staff	MetroHealth Center for Skilled Nursing Care	1988 - 1983
8.	Member	Associate Medical Staff	Health Hill Hospital	1988 - 1993
9.	Chief Psychologist	Children's Inpatient Unit	Bradley Hospital	1984 - 1987
10.	Neuropsychology Associate	Neuropsychology Laboratory	Hahnemann University Hospital	1983 - 1984
11.	Postdoctoral Fellow	Department of Psychology	Bradley Hospital	1982 - 1983

OTHER APPOINTMENTS

1.	Invited Reviewer	*Journal of Personality Assessment*	1988 to Present
2.	Ad Hoc Reviewer	*International Journal of Psychiatry in Medicine*	1987 to 1993

3.	Ad Hoc Reviewer	*Neuropsychology*	1987 - 1990
4.	Invited Reviewer	*Archives of Clinical Neuropsychology*	2002 - Present
5.	Co-Investigator	Cleveland Baby Study, MetroHealth Medical Center, CWRU School of Medicine	1988 to Present
6.	Certified Disability Evaluator Panel	Ohio Bureau of Worker's Compensation	1996 to Present
7.	Independent Medical Examiner	Industrial Commission of Ohio	1997 to Present
8.	Consultant	Caloh, Inc., Independent Medical Examiners	1996 to 2003
9.	Board of Trustees	Cleveland Psychological Association	1997 to 1998
	Co-Chair	Marketing Committee	1997 to 1998
10.	Consultant,	Department of Thoracic & Cardiovascular Surgery, Aultman Hospital, Canton, Ohio	1997 to 2002

HONORS & AWARDS

1.	Dean's List, University of Massachusetts; Graduated Magna Cum Laude	1975
2.	Elected, Outstanding Young Men in America	1983
3.	Elected, Who's Who in the Midwest (23rd Edition)	1992
4.	Elected, Who's Who Among Human Service Professionals (3rd Edition)	1992

PROFESSIONAL MEMBERSHIPS

Present

1.	Member (1717-1775)	American Psychological Association	1983 to Present
	Divisions:	Division 12 – Clinical Psychology Division 40 -- Clinical Neuropsychology Division 41 – American Psychology - Law Society Division 42 – Independent Practice	
2.	Member	International Neuropsychological Society	1985 to Present
3.	Member	Society for Personality Assessment	1986 to Present
4.	Member (Professional)	National Academy of Neuropsychology	1988 to Present
	Committees:	Membership Committee	1991 to 1993
		Research Consortium	1991 to Present
5.	Member (10290)	Ohio Psychological Association	1988 to Present
	Committees:	Quality Assurance Committee	1993 - 1996
6.	Member	Prescribing Psychologist's Register	1995 to Present
7.	Diplomate	American College of Forensic Examiners	1996 to Present
	Subcommittees for developing Standards:	Neuropsychology, Clinical Psychology, Clinical Psychology, Forensic Psychology, Psychological Assessment, Disabilities Evaluation	
8.	Member	Cleveland Psychological Association	1997 to Present
9.	Diplomate	American Board of Disability Analysts	1997 to Present

Past

1.	Member	Rhode Island Psychological Association	1985 - 1988
2.	Student Affiliate	American Psychological Association	1980 - 1982
3.	Associate Member	Pennsylvania Psychological Association	1980 - 1982
4.	Student Affiliate	Philadelphia Society of Clinical Psychologists	1980 - 1982

PUBLICATIONS

1. Boyd, T.A., Ernhart, C.B., & Greene, T.H. Prenatal alcohol exposure and sustained attention in the preschool years. (Abstract). *Psychiatry Digest*, in press.

2. Greene, T., Ernhart, C.B., Sokol, R.J., Martier, S., Boyd, T.A. & Ager, J. Neonatal Diagnosis of Fetal Alcohol Syndrome: Not Necessarily a Hopeless Prognosis. *Alcoholism: Clinical and Experimental Research*, 1995, 19 (6), 1550-1557.

3. Boyd, T.A. What have we forgotten: A developmental framework for clinical memory assessment of children. (Abstract). *Journal of Clinical and Experimental Neuropsychology*, 1995, 1 (4), 381.

4. Boyd, T.A. & Hooper, S.R. WISC-R IQ estimates from the Luria-Nebraska Neuropsychological Battery. *Perceptual and Motor Skills*, 1993, 77, 683-688.

5. Hooper, S.R., Boyd, T.A., Hynd, G.W., Rubin, J. Definitional issues and neurobiological foundations of selected neurodevelopmental learning disorders. *Archives of Clinical Neuropsychology*, 1993, 8, 279-307.

6. Greene, T., Ernhart, C.B. Boyd, T.A. Contributions of risk factors to elevated blood and dentine lead levels in preschool children. *The Science of the Total Environment*, 1992, 115, 239-260.

7. Cole, M., Winkelman, M., Morris, J., Simon, J.E., Boyd, T.A. Thalamic Amnesia: Korsakoff syndrome due to left thalamic infarction. *Journal of the Neurological Sciences*, 1992, 110, 62-67.

8. Greene, T.H., Ernhart, C.B., & Boyd, T.A. Contributions of risk factors to elevated blood lead levels in preschool children: Methodological implications. (Abstract). *Archives of Environmental Health*, 1991, 46, 187-188.

9. Boyd, T.A., Ernhart, C.B., & Greene, T.H. Prenatal and early childhood lead exposure and sustained attention in the preschool years. (Abstract). *Archives of Clinical Neuropsychology*, 1991, 6 (3), 178-179.

10. Ernhart, C.B., Greene, T. & Boyd, T.A. Response to H.L. Needleman, A. Schell, D. Bellinger, A. Leviton & E.N. Allred: The long-term effects of exposure to low doses of lead in childhood (Vol. 232, No. 2). (Letter). *New England Journal of Medicine*, 1991, 324 (6), 416.

11. Greene, T., Ernhart, C.B., Sokol, R.J., Martier, S., Marler, M., Boyd, T.A & Ager, J. Prenatal alcohol exposure and preschool physical growth: A longitudinal analysis. *Alcoholism: Clinical and Experimental Research*, 1991, 15, 905-913.

12. Boyd, T.A., Ernhart, C.B., Greene, T., Sokol, R. & Martier, S. Prenatal alcohol exposure and sustained attention in preschoolers. *Neurotoxicology and Teratology*, 1991, 13, 49-55.

13. Boyd, T.A., Ernhart, C.B., & Greene, T.H. Prenatal alcohol exposure and sustained attention in the preschool years. (Abstract). *Archives of Clinical Neuropsychology*, 1991, 6 (3), 178.

14. Greene, T., Ernhart, C.B., Ager, J., Sokol, R. Martier, S. & Boyd, T.A. Prenatal alcohol exposure and cognitive development in the preschool years. *Neurotoxicology and Teratology*, 1991, 13, 57-68.

15. Greene, T., Ernhart, C.B., Ager, J., Sokol, R. Martier, S. & Boyd, T.A. Prenatal alcohol exposure and cognitive development in the preschool years. (Abstract). *Pediatrics Digest*, 1991, 7-8.

16. Boyd, T.A. Clinical assessment of memory in children: Research, theory and prospects for practice. In M.G. Tramontana and S.R. Hooper (Eds.) Assessment Issues in Child Neuropsychology. New York: Plenum, 1988.

17. Boyd, T.A. & Hooper, S.R. WISC-R IQ estimates from the Luria-Nebraska Neuropsychological Battery. (Abstract). *Bulletin of the National Academy of Neuropsychologists*, 1988, 5 (1), 12.

18. Boyd, T.A. & Hooper, S.R. Psychometric validity of proration and Digit Span substitution for estimating WISC-R Verbal and Full Scale IQs. *Perceptual and Motor Skills*, 1987, 65, 19-25.

19. Hooper, S.R. & Boyd, T.A. Test review: The Denman Neuropsychology Memory Scale. *International Journal of Clinical Neuropsychology*, 1987, 9 (3), 141-144.

20. Boyd, T.A., Tramontana, M.G. & Hooper, S.R. Cross-validation of a psychometric system for screening neuropsychological abnormality in older children. *Archives of Clinical Neuropsychology*, 1987, 1, 387-391.

21. Hooper, S.R. & Boyd, T.A. Neurodevelopmental learning disorders. In J.E Obrzut and G.W. Hynd (Eds.) Child Neuropsychology: Clinical Practice (Vol. II). New York: Academic Press, 1986.

22. Boyd, T.A. & Tramontana, M.G. Application of the Split-Half WISC-R with emotionally and behaviorally disturbed children. *Journal of Psychoeducational Assessment*, 1986, 4 (2), 113-122.

23. Boyd, T.A. & Tramontana, M.G. WISC-R short forms: Long on problems. (Abstract). *Educational Resources Information Center (ERIC)*, U.S. Department of Education, National Institute of Education, February 3, 1986.

24. Tramontana, M.G. & Boyd, T.A. Psychometric screening of neuropsychological abnormality in older children. *International Journal of Clinical Neuropsychology*, 1986, 8 (2), 53-59.

25. Tramontana, M.G., Klee, S.H. & Boyd, T.A. WISC-R interrelationships with the Halstead-Reitan and Children's Luria Neuropsycholgocal Batteries. *International Journal of Clinical Neuropsychology*, 1984, 6, 1-8.

PRESENTATONS

1. Boyd, T.A., Konrad, K., Bruening, & Goshe, G. Why do they act that way: Brain Injury and Behavior. Interdisciplinary inservice, The Rehabilitation Hospital at Heather Hill, Chardon, Ohio, November, 1994.

2. Boyd, T.A., Konrad, K., & Livingston, R. Understanding adolescents (part I and II). Interdisciplinary inservice, The Rehabilitation Hospital at Heather Hill, Chardon, Ohio, October, 1994.

3. Boyd, T.A., Strenger, V.E., & Dickerson, P.B. Coping with illness: A family affair. Heather Hill Family Education Series. Heather Hill, Inc., Chardon, Ohio, May, 1994.

4. Boyd, T.A. What have we forgotten: A developmental framework for clinical memory assessment of children. Paper presented at the International Neuropsychological Society, Twenty-Second Annual Meeting. Cincinnati, Ohio, February 1994.

   Audiocassette Tape. Contained on G.A. Gioia, Organizer; G. Butterbaugh, Chair; E. Kaplan, Discussant: "Symposium 7: Developmental theory and process in the examination of children's memory. #G117-37AB, InfoMedix, Garden Grove, CA, 1994

5. Greene, T., Sokol, R.J., Martier, S., Ernhart, C.B., Boyd, T.A., & Ager, J. FAS: Not necessarily a hopeless prognosis. Paper presented at The 6th Congress of The International Society for Biomedical Research on Alcoholism, held jointly with the Research Society on Alcoholism. Marco Island, Florida, June 1991.

6. Boyd, T.A., Ernhart, C.B., & Greene, T.H. Prenatal alcohol exposure and sustained attention in the preschool years. Paper presented at the 10th Annual Meeting of the National Academy of Neuropsychology. Reno, Nevada, November 1990.

7. Boyd, T.A., Ernhart, C.B., & Greene, T.H. Prenatal and early childhood lead exposure and sustained attention in the preschool years. Paper presented at the 10th Annual Meeting of the National Academy of Neuropsychology. Reno, Nevada, November 1990.

8. Boyd, T.A. Comments on the Wide Range Assessment of Memory and Learning (WRAML). Symposium: Assessing Memory in Children: A new test battery. Paper presented at the 98th Annual Convention of the American Psychological Association. Boston, MA, 1990.

9. Greene, T., Ernhart, C.B. & Boyd, T.A. Contributions of risk factors to elevated blood lead levels in preschool children: Methodological implications. Paper presented at The 2nd Annual Meeting of the International Society for Environmental Epidemiology (ISEE). Berkeley, California, August 1990.

10. Greene, T., Ernhart, C.B., Sokol, R.J., Agar, J., Martier, S. & Boyd, T.A. Fetal alcohol exposure and cognitive development. Paper presented at The 5th Congress of The International Society for Biomedical Research on Alcoholism, held jointly with the Research Society on Alcoholism. Toronto, Canada, June 1990.

11. Boyd, T.A. Developmental and psychosocial impact of closed head injuries in children. Paper presented at special conference, Pediatric Seizure Disorders and Closed Head Injuries: A challenge to Health Care Professionals and Families. Continuing Education Division, Education and Training, the MetroHealth System, December 1989.

12. Boyd, T.A., Irwin, M. & Fristad, M.A. Serial Rorschach data in childhood bipolar illness. Paper presented at the Annual Midwinter Meeting of the Society for Personality Assessment. New Orleans, Louisiana, March 1988.

13. Boyd, T.A. & Hooper, S.R. WISC-R IQ estimates from the Luria-Nebraska Neuropsychological Battery. Paper presented at the Seventh Annual Meeting of the National Academy of Neuropsychologists. Chicago, Illinois, October 1987.

14. Boyd, T.A. Clinical assessment of memory in children: Toward a practical solution. Paper presented at the 94th Annual Convention of the American Psychological Association. Washington, DC, 1986.

15. Hayden, R. & Boyd, T.A. MMPI-168 regression equations with Adolescents: Derivation and cross validation. Paper presented at the 94th Annual Convention of the American Psychological Association, Washington, DC, 1986.

16. Boyd, T.A. The utility of neuropsychological testing in detecting CNS impairment in SLE patients. Grand Rounds, Division of Rheumatology, Brown University Program in Medicine and Roger Williams General Hospital, May 1985.

17. Boyd, T.A. & Tramontana, M.G. WISC-R short forms: Long on problems. Paper presented at the 92nd Annual Convention of the American Psychological Association, Toronto, Canada, 1984.

18. Tramontana, M.G., Boyd, T.A. & Sherrets, S.D. Predicting the long range effects of early childhood brain damage: A lesson in humility. Special Grand Rounds, Department of Psychiatry and Human Behavior, Brown University Program in Medicine and Bradley Hospital, August 1983.

19. Tramontana, M.G., Boyd, T.A. & Sherrets, S.D. Psychometric screening of neuropsychological abnormality in older children. Paper presented at the 91st Annual Convention of the American Psychological Association, Anaheim, CA, 1983.

TEACHING ACTIVITIES

Training Duties

1. Supervisor, PGY-III and PGY-II Residents in Psychiatry, Case Western Reserve University School of Medicine and Department of Psychiatry, MetroHealth Medical Center, 1988 - 1993.
2. Supervisor, Practicum in Adult Psychological Assessment, Doctoral students in Clinical Psychology, Case Western Reserve University, MetroHealth Medical Center campus, 1988 - 1993
3. Supervisor, Field Placement in Adult Psychological Assessment, Doctoral students in Clinical Psychology, Case Western Reserve University, MetroHealth Medical Center campus, 1991 - 1993
4. Supervisor, Rotations in Clinical Child Psychology (Bradley Hospital), Brown University Clinical Psychology Internship Consortium, 1984 - 1987.
5. Supervisor, Rotations in Clinical Child Neuropsychology (Bradley Hospital), Brown University Clinical Psychology Internship Consortium, 1984 - 1987.
6. Supervisor, Postdoctoral Fellowship in Clinical Child Neuropsychology, Bradley Hospital and Brown University, 1984-1986.
7. Supervisor, Rotation in Clinical Neuropsychology, Hahnemann University "Captive" Internship Training Program, 1983 - 1984.
8. Supervisor (partial), Clinical Child Neuropsychology (Bradley Hospital), Brown University Clinical Psychology Internship Consortium, 1982 - 1983.

Lectures & Courses Taught

1. Adult Psychological Testing, Medical Student Clerkship (Rotation in Psychiatry),Case Western Reserve University School of Medicine and Department of Psychiatry, MetroHealth Medical Center, 2-Part Lecture (Given quarterly), 1990 - 1993
2. Adult Psychological Testing, PGYII and PGY-III Residents in Psychiatry, Case Western Reserve University School of Medicine and Department of Psychiatry, MetroHealth Medical Center, 5-Part Seminar (annually), 1988 -1993.
3. Neuropsychological Assessment in Outcome Studies for Acute Head Injury (partial), Residents in Neurology, Case Western Reserve University School of Medicine and Department of Neurology, MetroHealth Medical Center, Lecture, Spring, 1991.
4. Introduction to Psychological Testing, School of Nursing, MetroHealth Medical Center, Quarterly Lecture, 1990.
5. Neuropsychological Assessment in Acute Head Injury, Residents in Neurology and Rehabilitation Medicine, Case Western Reserve University School of Medicine and Department of Neurology, MetroHealth Medical Center, Lecture, Fall 1989 - 1992.
6. Research Issues in Child Neuropsychology, Case Western Reserve University, Department of Psychology, Graduate Program in Clinical Psychology, Pediatric Psychology Track, Lecture, Fall 1987.

7. Attention Deficit Disorder, Brown University Clinical Psychology Internship Consortium, Spring Lecture, 1986.
8. Clinical Assessment Methods with Children, Brown University Clinical Psychology Internship Consortium, Fall lecture, 1985 - 1986.
9. Psychological Assessment, Psychiatry Residents and Fellows in Child Psychiatry, Department of Psychiatry and Human Behavior, Brown University Program in Medicine, Summer lecture, 1985.
10. Basic Measurement in Psychodiagnostics, Department of Mental Health Sciences, The Graduate School, Hahnemann University, Full Course, Spring Semester, 1984.
11. History of Psychology, Department of Mental Health Sciences, The Graduate School, Hahnemann University, Full Course, Spring Semester, 1984.
12. Theories of Learning and Motivation, Department of Mental Health Sciences, The Graduate School, Hahnemann University, Full Course, Fall Semester, 1983.
13. Physiological Basis of Behavior, Department of Mental Health Sciences, The Graduate School, Hahnemann University, Full Course, Fall Semester, 1983.
14. Clinical Neuropsychology, Brown University Clinical Psychology Internship Consortium, 4-Part Seminar (partial), 1982 - 1983.
15. Neuropsychology of Language, Department of Speech Pathology, Hahnemann University, Spring Seminar Lectures, 1982.
16. Social Psychology, College of Allied Health Professions, Hahnemann University, Full Course, 1977 - 1979.
17. Juvenile Delinquency, Orchard Hill Residential College, University of Massachusetts, Amherst, Seminar, 1973 - 1974.
18. Practicum in Youth Work, Orchard Hill Residential College, University of Massachusetts, Amherst, 1973 - 1974.

GRANTS

1. Executive Board of the Cuyahoga County Hospital Auxiliary. December 1987. Awarded $4,671.00 for purchase of IBM-compatible portable computer for Psychological Assessment Center.
2. Research Initiation Grant, Ohio Board of Regents and Case Western Reserve University. 1988. Awarded $5,000.00 for study entitled Neuropsychiatric Profiles of Lupus Patients with Patterns of High and Low Utilization of Clinic Services.

REFERENCES: Professional references are available upon request.

IN THE COURT OF COMMON PLEAS
TRUMBULL COUNTY OHIO

STATE OF OHIO,	)	CASE NO. 01-CR-794
	)	
Plaintiff,	)	JUDGE JOHN M. STUARD
	)	
-vs-	)	**OPINION OF THE COURT**
	)	
NATHANIEL E. JACKSON,	)	**FINDINGS OF FACT AND CONCLUSIONS OF LAW REGARDING**
	)	
Defendant.	)	**IMPOSITION OF DEATH PENALTY**

On November 8, 2002, a Trumbull County Jury returned a verdict finding the Defendant, Nathaniel E. Jackson, guilty of two (2) counts of Aggravated Murder arising from the death of Robert S. Fingerhut. Since Count One and Count Two of the Indictment merge for sentencing purposes, the State elected to dismiss Count Two and proceed to the mitigation phase on the first count of the indictment. Therefore, for purposes of this opinion, the Defendant was convicted, under the first count of the indictment, of purposely, and with prior calculation and design, causing the death of Robert S. Fingerhut. The jury further found that the State had proved beyond a reasonable doubt two (2) specifications of aggravating circumstances. After the mitigation hearing, the jury concluded that the State had proved beyond a reasonable doubt that the aggravating circumstances outweighed the mitigating factors and returned a verdict recommending that the sentence of death be imposed upon the Defendant.

Factually, the evidence revealed that while the Defendant was in prison for a prior conviction unrelated to the present case, he along with the Co-Defendant, Donna Roberts, who is precedently awaiting trial for her involvement, plotted the murder of her house mate, and ex-husband, Robert S. Fingerhut. Indeed, both of them concocted a plan to kill Fingerhut to permit

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the Defendant and Roberts to live happily ever after. However, the plan went awry when Jackson, who was in the house where Fingerhut stayed, was shot in the left index finger during the execution of Fingerhut. He then took Fingerhut's car keys, and drove the vehicle which Fingerhut typically operated to Youngstown. Shortly thereafter, Roberts took the Defendant to a motel in Boardman, getting him a room where he could hide out. Ultimately, the Defendant was captured at a home in Youngstown, and he gave a statement to the police alleging self-defense.

More specifically, the State introduced evidence that on December 11, 2001, two (2) days after the Defendant was released from prison, Robert S. Fingerhut, while in his home, was pistol whipped, and shot three(3) times, causing at least four (4) injuries from gun shots. Two of the injuries were to the back, with one grazing the back, and the other entering near the shoulder before exiting out the chest area of the victim. Fingerhut also sustained a defensive gun shot wound to the webbing of his left hand between the thumb and forefinger. The fatal gun shot was to the top of the head and from a short distance. This injury would "would have dropped him like a sack of potatoes," as testified to by Dr. Germaniuk.

Police responded to the crime scene as a result of a 911 call. When they arrived at approximately 12:01 a.m., they were met by the Co-Defendant, who informed them that her husband's car was missing. She also granted them permission to search the residence and her car. During this search, police found more than 140 letters from the Defendant to Roberts in her dresser, and an equal number of letters from Roberts to the Defendant, in the trunk of the Co-Defendant's car, in a paper bag bearing the Defendant's name and prison number.

Additionally, law enforcement officers were able to obtain nineteen (19) telephone

conversations, lasting more than three (3) hours, which were recorded while the Defendant was incarcerated in Lorain Correctional Institution. These telephone conversations, along with the letters which spanned three (3) months, revealed a continuing and evolving plan to kill Fingerhut immediately upon the Defendant's release from prison.

Specifically, during these telephone conversations, and in the written letters, the Defendant requested that Roberts obtain for him, black gloves to conceal his fingerprints, a ski mask, and a pair of handcuffs. Further, the Defendant, during the December 8, 2001, telephone conversation, which was recorded the day before he was discharged from Lorain, and three (3) days before the murder, stressed to Roberts that he "need[ed] to be in the house [in which Fingerhut lived] before he [got] home" in order to carry out the premeditated murder. Roberts, in a letter written to the Defendant acknowledged that she has found thin, fleece line, leather gloves, but was still looking for the ski mask.

Indeed, the State introduced black leather gloves with fleece lining which were recovered from the house where the Defendant was arrested. These gloves, which had gun shot residue on them, had a hole in the left index finger, and a reddish substance which appeared to be blood was also observed in that same area. This damaged matched the injury that the Defendant had sustained to his finger. Although the actual handcuffs were never recovered by police, an empty handcuff box was found in Donna Robert's car.

The evidence also revealed that Roberts, near the time of the murder, was seen driving her automobile in a very slow manner away from the vicinity of the home where Fingerhut lived. Furthermore, within two (2) hours from the last time Fingerhut was seen alive, Roberts rented a hotel room for the Defendant. In this room, bloody bandages and other medical supplies were

found by hotel cleaning people and were subsequently collected by police.

The car which was usually driven by Fingerhut, and which had been reported stolen by the Co-Defendant the night of Fingerhut's murder was recovered in Youngstown, Ohio. Blood stains were located throughout the vehicle and were collected by law enforcement. DNA analysis revealed that the blood matched that of DNA profile of the Defendant.

The State also introduced evidence that Roberts and the Defendant discussed purchasing a "new Lincoln" or "2002 Cadillac DeVille" for the Defendant. Additionally, Fingerhut had two (2) life insurance policies with a total death benefit of $550,00.00, and with Donna Roberts named as the beneficiary.

Based upon this and other evidence, the jury properly concluded that the Defendant committed a burglary to facilitate the premeditated and purposeful murder of the victim Fingerhut along with Roberts. The Defendant after executing his plan then stole Fingerhut's vehicle which allowed the jury to find that the murder was committed while committing the aggravating circumstances of Aggravated Burglary and Aggravated Robbery.

In a case of this nature, pursuant to R.C. 2929.03(D)(3), the Court is required to determine whether the State has proved beyond a reasonable doubt that the aggravating circumstances outweigh the mitigating factors. Indeed, the Supreme Court of Ohio has stated in *State v. Wogenstahl* (1996), 75 Ohio St. 3d 344:

> "[T]he nature and circumstances of the offense may only enter into the statutory weighing process on the side of mitigation. *** [I]n the penalty phase of a capital trial, the 'aggravating circumstances' against which the mitigating evidence is to be weighed are limited to the specifications of aggravating circumstances set forth in R.C. 2929.04(A)(1) through (8) that have been alleged in the indictment and proved beyond a reasonable doubt." *Wogenstahl* (1996), 75 Ohio St. 3d 344 at 356.

In performing its statutory duty, the a review of the aggravating circumstances is required.

1.) *The Defendant committed the Aggravated Murder while he was committing, attempting to commit, or fleeing immediately after committing Aggravated Burglary and that he was the principal offender.*

The evidence presented at trial reflected that the Defendant trespassed in the victim's dwelling and murdered him. The Court finds that the Defendant entered into 254 Fonderlac Drive, in Howland Township. He was wearing gloves and armed with a gun, with which he struck the victim leaving a mark on Fingerhut's face. Once in the house, he fired the gun three times causing four (4) separate wounds. The fatal shot was to the top of Fingerhut's head, and nearly straight down.

From the aforementioned evidence, the Jury concluded that the defendant committed the Aggravated Murder of while he was committing, attempting to commit, or fleeing immediately after committing Aggravated Burglary and that he was the principal offender.

2.) *The Defendant committed the Aggravated Murder while he was committing, attempting to commit, or fleeing immediately after committing Aggravated Robbery and that he was the principal offender.*

After the Defendant had murdered the victim, he took the victim's car keys and his car As he was driving away from the crime scene, and prior to abandoning the vehicle in Youngstown, he left blood evidence throughout the car. This evidence was subjected to DNA testing, which confirmed that forensically, it was his blood. Quite simply, the Defendant committed the Aggravated Robbery to escape the consequences of his prior murderous act.

This evidence permitting the jury to conclude that the Defendant committed the Aggravated Murder while he was committing, attempting to commit, or fleeing immediately after committing Aggravated Robbery and that he was the principal offender.

To be weighed against the aggravating circumstances are the mitigating factors. In this case, the following factors were considered by the Court as possible mitigation against each specification and against the imposition of the death penalty:

1.) *The nature and circumstances of the offense, the history, character, and background of the offender.*

As was noted in *Wogenstahl, supra*, the nature and circumstances of the offense may only enter into the statutory weighing process on the side of mitigation. However, in this case, reviewing the nature and circumstances, the Court does not find any credible evidence which would allow the Court to accord any weight to the nature and circumstances of the offense against the imposition of the death penalty.

In considering the history, character and background of the offender, this Court considered the home life of the Defendant and the fact that he grew up in a relatively poor environment, and that he was cared for and raised by his mother and maternal grandmother. His biological father had little, if any, real involvement with him, and this lack of a father figure likely contributed to his behavioral problems .

Though the Court gives some weight to the Defendant's upbringing, it deserves little weight because of the credible testimony from the Defendant's step-father, his sister, his mother, and Dr. McPherson. These witnesses testified that the Defendant was respectful to both is mother and grandmother. His sister, who described as smart and really kind, noted that they

attended church. Further, there was testimony offered that he was reared in an environment, where he was not physically or sexually abused. His mother also declined to say that his home was in a "rough neighborhood, or that the Defendant had any problems in school. Dr. McPherson's report noted that the Defendant had not been hospitalized for any physical or mental condition. The witnesses also noted that they practiced moral tenets and that responsibility and respect were taught.

In conclusion, from the testimony of these witnesses, there is nothing particularly evident to show an unusual childhood or to offer an explanation for the Defendant's behavior which would be entitled any significant weight on the side of mitigation.

2.) *Whether the victim of the offense induced or facilitated the killing.*

Although under R.C. 2929.04(B)(1), the mitigating factor regarding whether the victim of the offense induced or facilitated it was not specifically argued by the Defendant during the penalty phase of the trail as mitigating, the Court did consider the Defendant's video taped statement presented in evidence during the trial phase. In the self-serving statement, the Defendant claimed that the killing of the victim was as a result of the Defendant protecting himself from an unprovoked attack by the victim.

This statement to the police attempted to construct a scenario wherein the victim approached the Defendant to purchase marijuana and then invited the Defendant into his home. The Defendant then claims that the victim then pulled a gun on him. The Defendant asserted that he attempted to disarm the victim, but the gun went off apparently striking the victim. However, the other facts illustrating the planning and execution of the murder along with the physical evidence introduced causes the Defendant's version not to be credible. As such, the

Court does not accord any weight to this mitigating factor.

3.) *Whether it is unlikely that the offense would have been committed, but for the fact that the offender was under duress, coercion, or strong provocation.*

Again, while the Defendant did not specifically argue this mitigating factor, the Court, upon reviewing the video tape, noticed that the Defendant claimed that the victim made derogatory statements about the Defendant's race which angered the Defendant. However, the this comment is likewise not convincing for the same reasons noted previously. This mitigating factors has no weight.

4.) *Any other factors that are relevant to the issue of whether the offender should be sentenced to death.*

Under R.C. 2929.04 (B)(7), commonly referred to as the "catch all provision" the Court reviewed the Defendant's capacity to appreciate the criminality of his conduct in light of the defense expert testimony regarding his mental history and mental state at the time of the offense was considered as a possible factor under R.C. 2929.04(B)(3).

This testimony revealed that the Defendant suffered from Attention Deficit Disorder/Hyperactivity Disorder, Chemical Dependency, and a reported history of alcohol abuse. Further, the evidence disclosed that the Defendant had an Antisocial Personality Disorder and was considered low average or better in intelligence.

Significantly, however, there was no evidence presented that the Defendant, at the time of the offense, had any mental disease or defect or that he lacked the capacity to appreciate the criminality of his conduct. His Antisocial Personality Disorder only showed that he had a history of inappropriate and impulsive behavior from his early childhood to the present. He was

incarcerated four (4) times. According to the Defendant's own expert, the Defendant, throughout his juvenile and adult life had received repeated treatment and/or probation for his criminal transgressions and his drug and alcohol abuse. He did not learn from his past mistakes, but only escalated his antisocial conduct.

In summary, this Court gives very little weight in mitigation to the Defendant's mental status, and his drug and alcohol abuse history especially in light of the Defendant's elaborate scheme to kill the victim, elude capture, and finally deceive police officers with a statement blaming the victim.

Further under 2929.04(B)(7), the Court examined the Defendant's ability to maintain himself in a stable fashion in a structured setting. Indeed, it was suggested by the Defense that he could be a productive member of the general prison population, and that this should be considered as mitigating. However , the Court gives slight weight to this particular factor.

The Defendant's last incarceration was the result of him not learning from his past mistakes, and from his tendency to act out impulsively without looking at the consequences. Furthermore, he repeatedly was placed on probation, but he continued to digress, committing more serious criminal acts. Indeed, during the last incarceration, the Defendant claimed to have "found God" and that he was going to straighten out his life. At the same time, it is abundantly clear that he was plotting to commit the ultimate criminal act, a premeditated burglary and murder, while pre-textually presenting himself to prison officials as a good candidate for a release program. Quite simply, in the very setting in which the Defense suggests that he could be a productive member, the Defendant defined and refined a plot, involving gloves, a mask and handcuffs, to murder Robert S. Fingerhut so that in effect he could assume Fingerhut's lifestyle,

including running the Greyhound bus business, managing rental properties, and living in his home with his ex-wife.

The Defendant also offered an unsworn statement, wherein he stated that he was "very sorry for what happened." The Court likewise gives this statement slight weight as the statement lacked sincerity. The tone and tenor of the apology did not, in the Court's opinion, come from someone who was genuinely remorseful. Even assuming that the Defendant was remorseful, such retrospective remorse is not entitled to any significant weight. To the contrary, the Court believes that the Defendant's feigned remorse stems from the fact that the Defendant was apprehended. The Defendant was disappointed that the fool-proof, premeditated murder plot ,which he developed over nearly three (3) months, and which included shooting the victim "in the 'F' ing head," failed.

When independently weighing the aggravating circumstances as to the Aggravated Murder as previously outlined against the collective factors in mitigation, this Court finds that the aggravating circumstances not only outweigh the mitigating factors by proof beyond a reasonable doubt, but in fact, they almost completely overshadow them.

The State of Ohio has recognized that under certain circumstances, the death penalty is an appropriate sanction to any defendant who commits an Aggravated Murder during the commission of these certain felonies. In the case at bar, the underlying felonies are Aggravated Burglary and Aggravated Robbery.

In this particular case, the Court accords substantial weight to the Aggravated Burglary specification. In order to prove an Aggravated Burglary, the State is required to demonstrate that the Defendant trespassed in the occupied structure for the purpose of committing a criminal

act. In most instances, this criminal act is a theft offense. Occasionally, a Defendant will trespass to commit a kidnapping or even a rape. Such criminal acts provide the basis upon which a Defendant can be convicted of Aggravated Burglary. Then, if during any of these underlying criminal acts, the victim is purposely killed, an Aggravated Murder with the specification of Aggravated Burglary has been committed. These alone can permit the imposition of the death penalty should the aggravating circumstance of the Aggravated Burglary be found to outweigh the mitigating factors.

Under the facts in the instant case, this Court can not foresee of any other form of Aggravated Burglary where the weight to be given to this aggravating circumstance could ever be greater. The evidence reveals that the sole purpose for the Defendant's illegal entry in the Fingerhut residence was not to commit a theft, a kidnapping or a rape, but to rather to carry out the premeditated, cold blooded execution Robert S. Fingerhut. This is the most heinous form of Aggravated Burglary, and it is entitled to unsurpassed weight. Further, in this Court's view, this aggravating circumstance, standing alone, outweighs all of the evidence presented in mitigation.

The Court further gives weight to the Aggravated Robbery specification. After shooting the Defendant in the head, the Defendant took personal property of the victim to effectuate his escape. Indeed, the Defendant stole the victim's keys and his car.

Against this backdrop, the mitigating factors of the Defendant's background, history and character, his Antisocial Personality Disorder, his Attention Deficit Disorder, his history of drug and alcohol abuse, as well as his unsworn statement, have very little effect in minimizing, lessening, or excusing the degree of the Defendant's murderous conduct. From the

overwhelming evidence, it is this Court's opinion that the Defendant and the Co-Defendant plotted the murder of Robert S. Fingerhut solely to collect $550,00.00 in insurance proceeds. This was accomplished by trespassing in the residence where Fingerhut resided, for the sole purpose of ambushing and murdering him.

Upon consideration of the relevant evidence raised at trial, the relevant testimony, the other evidence, the unsworn statement of the defendant, and the arguments of counsel, it is the judgment of this Court that the aggravating circumstances, outweighed, by proof beyond a reasonable doubt, the collective mitigating factors.

Dated: 12/9/02

HON. JOHN M. STUARD
Judge, Court of Common Pleas

I hereby certify that a copy of the foregoing opinion was hand delivered to Attorney James Lewis, Attorney Anthony Consoldane, and Prosecutor Dennis Watkins this 9th day of December, 2002.

HON. JOHN M. STUARD

I also hereby certify that a copy of the foregoing opinion was duly mailed by ordinary U.S. Mail to the Clerk of the Supreme Court, Supreme Court of Ohio, State Office Tower, 30 E. Broad Street, Columbus, Ohio 43266-0419, this 9th day of December, 2002.

HON. JOHN M. STUARD

DEC 9 11 46 AM '02

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO, EASTERN DIVISION

LEWIS WILLIAMS, JR., and
JOHN G. ROE,

Plaintiffs,

v.

ROBERT TAFT,
REGINALD WILKINSON, and
JAMES HAVILAND,

Defendants.

AFFIDAVIT OF MARK J. S. HEATH, M.D.,
BOARD CERTIFIED ANESTHESIOLOGIST

I, Mark J. S. Heath, after being duly sworn and cautioned, hereby affirm as follows:

1. My name is Mark J. S. Heath, M.D., I am an Assistant Professor of Clinical Anesthesiology in the Department of Anesthesiology at Columbia University in New York City, N.Y. I received my Medical Doctorate degree from the University of North Carolina at Chapel Hill in 1986 and completed residency and fellowship training in Anesthesiology in 1992 at Columbia University Medical Center. I am Board Certified in Anesthesiology, and am licensed to practice Medicine in New York State. My work consists of approximately equal parts of performing clinical anesthesiology, teaching residents, fellows and medical students, and managing a neuroscience laboratory. As a result of my training and research I am familiar and proficient with the use and pharmacology of the chemicals used to perform lethal injection.

2. Over the past several years, as a result of concerns about the mechanics of lethal injection as practiced in the United States, I have performed several hundred hours of research into the techniques that are used during this procedure. I have been admitted as an expert medical witness in courts in Georgia, Tennessee, Pennsylvania, and Louisiana. I have filed affidavits that have been reviewed by courts in the above states and also Virginia, New York, Alabama, and by the United States Supreme Court. During court proceedings I have heard testimony from prison wardens who are responsible for conducting executions by lethal injection. I have testified before the Nebraska Senate Judiciary Committee regarding proposed legislation to adopt lethal injection. My research regarding lethal injection has involved both extensive conversations with recognized experts in the field and personal correspondence with the individuals responsible for introducing lethal injection as a method of execution in Oklahoma and the United States.

3. My qualifications are further detailed in my curriculum vitae, a copy of which is attached hereto as Exhibit A and incorporated by reference as if fully rewritten herein.

4. I have reviewed the following information regarding Ohio's lethal injection procedures: a letter written by Warden James S. Haviland and dated April 19, 2002, and a letter written by attorney Vincent Lagana, staff counsel for the Ohio Department of Rehabilitation and Correction, and dated May 30, 2002. *See* Exhibit B (Warden Haviland's letter) and Exhibit C (attorney Lagana's letter). This information was provided by attorney Gregory W. Meyers. He informed me that a colleague of his tried to obtain additional details from a representative of Ohio's prison system, but that those attempts proved unsuccessful.

5. The information contained in these two letters raises the following concerns about the Ohio lethal injection procedure. These concerns arise both from the details disclosed in the letters and from medically relevant, logical inferences drawn from the omission of details in the letters (*e.g.*, details regarding the training of the personnel involved; details of all of the medical equipment used; and details of the precise methods by which the personnel involved use the equipment to carry out an execution by lethal injection).

6. The letters by Warden Haviland and attorney Lagana state that as part of its protocol for lethal injection Ohio uses the drugs sodium thiopental (also know as "thiopental sodium" and "pentothal"), pancuronium bromide (also know as "pancuronium" and "Pavulon"), and potassium chloride (also known as "KCl")

7. The information that is provided does not indicate the sequence in which the three drugs are administered during the course of an execution. While no sequence of the above three drugs is acceptable (because of the use of pancuronium), if thiopental is administered as the second or third drug the execution is virtually certain to constitute torture. Even if I assume that thiopental is the first drug administered, significant concerns remain based on the matters discussed below.

8. A major concern about the protocol relates to the use of the drug pancuronium bromide. Pancuronium paralyzes all voluntary muscles, but does not affect sensation, consciousness, cognition, or the ability to feel pain and suffocation. If the thiopental and potassium are to be given in doses sufficient to cause death, then it is my opinion held to a reasonable degree of medical certainty that there would be no rational or medically justifiable place in the protocol for pancuronium.

9. If thiopental is not properly administered in a dose sufficient to cause death or at least the loss of consciousness for the duration of the execution procedure, then it is my opinion held to a reasonable degree of medical certainty that the use of pancuronium places the condemned inmate at risk for consciously experiencing paralysis, suffocation, and the excruciating pain of the intravenous injection of high dose potassium chloride.

10. Based on the information available to me, it is my opinion held to a reasonable degree of medical certainty that Ohio's lethal injection protocol creates an unacceptable risk that the inmate will not be anesthetized to the point of being unconscious and unaware of pain for the duration of the execution procedure. If the inmate is not first successfully anesthetized, then it is my opinion to a reasonable degree of medical certainty that the pancuronium will paralyze all voluntary muscles and mask external, physical indications of the excruciating pain being experienced by the inmate during the process of suffocating (caused by the pancuronium) and having a cardiac arrest (caused by the potassium chloride).

11. If administered alone, a lethal dose of pancuronium would not immediately cause a condemned inmate to lose consciousness. It would totally immobilize the inmate by paralyzing all voluntary muscles and the diaphragm, causing the inmate to suffocate to death while experiencing an intense, conscious desire to inhale. Ultimately, consciousness would be lost, but it would not be lost as an immediate and direct result of the pancuronium. Rather, the loss of consciousness would be due to suffocation, and would be preceded by the torment and agony caused by suffocation.

12. If taken alone, a lethal dose of potassium chloride would not immediately cause a condemned inmate to lose consciousness. It would first cause excruciating pain as it traveled through the venous system to the heart, and, once it reached the heart, it would cause a painful cardiac arrest that would deprive the brain of oxygen and rather quickly (but not immediately) cause death. If pancuronium were administered prior to the potassium chloride any visible signs of pain or agony caused by the potassium would be completely masked and undetectable to onlookers or witnesses.

13. It is my understanding that Ohio's execution protocol requires the presence of media witnesses to the execution, and permits the presence of witness chosen by the inmate and chosen by the victim's surviving family members. It is my opinion based on a reasonable degree of medical certainty that the use of pancuronium effectively nullifies the ability of witnesses to discern whether or not the condemned prisoner is experiencing a peaceful or agonizing death. Regardless of the experience of the condemned prisoner, whether he or she is deeply unconscious or experiencing the excruciation of suffocation, paralysis, and potassium injection, he or she will appear to witnesses to be serene and peaceful due to relaxed, totally immobile facial and other skeletal muscles.

14. Based on my research into issues related to lethal execution, I know that there was a time when pancuronium was an acceptable drug for use by veterinarians in the euthanasia of household pets such as dogs and cats; but that the use of pancuronium is now prohibited by many veterinary guidelines in this and other countries for precisely the reasons outlined above. Veterinary standards forbid creating the risk that household pets would die while pancuronium masks the type of excruciating pain

human beings are exposed to in Ohio's execution protocol. The use of pancuronium fails to comport with the evolving "standard of decency" regarding the ending of life in household pets. In my medical opinion, based on a reasonable degree of medical certainty, the use of pancuronium in the lethal injection protocol for executing human beings violates standards of decency designed to prevent the infliction of excruciating pain and suffering on human beings.

15. Another major concern I have based on what I know about Ohio's lethal injection protocol relates to the use of sodium thiopental. Sodium thiopental is an ultrashort-acting barbiturate with a very short shelf life in liquid form. Thiopental is distributed in powder form to increase its shelf life; it must be mixed into a liquid solution by trained personal before it can be injected.

16. When anesthesiologists use sodium thiopental, we do so for the purposes of temporarily anesthetizing patients for sufficient time to intubate the trachea and institute mechanical support of ventilation and respiration. Once this has been achieved, additional drugs are administered to maintain a "surgical plane" of anesthesia (*i.e.*, a level of anesthesia deep enough to ensure that a surgical patient feels no pain and is unconscious for the duration of the surgical procedure). The medical utility of thiopental derives from its ultrashort-acting properties: if unanticipated obstacles hinder or prevent successful intubation, patients will quickly regain consciousness and will resume ventilation and respiration on their own.

17. The benefits of thiopental in the operating room engender serious risks in the execution chamber. Based on the information I have available to me concerning Ohio's execution protocol, a two (2) gram dose of sodium thiopental is apparently administered in a single injection from a single syringe. By contrast, based on my research and the research of others into the procedures for executing human beings by means of lethal injection, the original design of the lethal injection protocol called for the **continuous** intravenous administration of an ultrashort-acting barbiturate. Based on my research and the research of others, the central elements of the lethal-injection procedure used in Ohio is similar to the one adopted many years ago in Oklahoma (which, it appears, many states used as a model without substantive independent research). Oklahoma requires the "continuous intravenous administration of an ultrashort-acting barbiturate" (Oklahoma Statutes, Title 22 Criminal Procedure, Chapter 17 part 1014 A). It does not appear that Ohio's protocol includes this "continuous" requirement. The use of a continuous administration of the ultrashort-acting barbiturate is essential to ensure continued and sustained unconsciousness during the administration of pancuronium and potassium chloride. It is my opinion based on a reasonable degree of medical certainty that the failure to require a continuous infusion of thiopental places the condemned inmate at a needless and significant risk for the conscious experience of paralysis during the excruciating pain of both suffocation and the intravenous injection of potassium chloride.

18. Based on my research into lethal injection, the dose of pentothal described in the Ohio protocol, 2 grams, is considerably lower than the doses described

in the protocols of many states and the Federal Government. It is my opinion based on a reasonable degree of medical certainty that Ohio's relatively low dose of thiopental amplifies the concern relating to the single injection (as opposed to continuous infusion) of this ultrashort-acting barbiturate, thereby further elevating the risk that the condemned person will suffer excruciating pain masked by the pancuronium.

19. The information provides no specifications regarding the timing of the administration of the drugs, thereby compounding the risks I am describing in this affidavit. This concern is greatly amplified by the use of an ultrashort-acting barbiturate.

20. Above and beyond my concerns stated above about the drugs used in Ohio, the details of Ohio's lethal injection protocol that I have been made aware of do not account for procedures designed to ensure the proper preparation of the drugs used. I have not seen details regarding the credentials, certification, experience, or proficiency of the personnel who will be responsible for the mixing of the thiopental from powder form, or for the drawing up of the drugs into the syringes. Preparation of drugs, particularly for intravenous use, is a technical task requiring significant training in pharmaceutical concepts and calculations. It is my opinion based on a reasonable degree of medical certainty, and based on my review of lethal execution procedures in states that have disclosed more detailed information that what I have seen about Ohio's procedures, that there exist many risks associated with drug preparation that, if not properly accounted for, further elevate the risk that an inmate will consciously experience excruciating pain during the lethal injection procedures.

21. Based on information in attorney Lagana's letter, it is possible that Ohio intends to employ one or more phlebotomists to administer the drugs by "hand infusion". In general, phlebotomists are neither trained nor certified to administer drugs. Rather, phlebotomists are trained primarily to collect blood specimens by venipuncture and capillary puncture. The personnel performing the lethal injection procedure should be trained, experienced, and proficient in the use and administration of intravenous drugs. It is my opinion based on a reasonable degree of medical certainty, and based on what I know about Ohio's lethal injection procedures, that if Ohio inappropriately relies on phlebotomists during the execution procedure, that fact demonstrates that Ohio designed its procedure without proper guidance from persons with requisite training in the areas of medical science implicated by Ohio's lethal injection protocol.

22. The information available to me provides inadequate detail regarding the training, credentials, certification, experience, or proficiency of any prison employee, nurse or paramedic who performs the execution procedure. The absence of such detail raises critical questions about the degree to which condemned inmates risk suffering excruciating pain during the lethal injection procedure. It is my opinion based on a reasonable degree of medical certainty that the correct and safe management of intravenous drug and fluid administration requires a significant level of professional acumen, and can not be adequately performed by personnel lacking the requisite

training and experience. The great majority of nurses are not trained in the use of ultrashort-acting barbiturates; indeed, this class of drugs is essentially only used by nurses who have significant experience in intensive care units and as nurse anesthetists. Very few paramedics are trained or experienced in the use of ultrashort-acting barbiturates. Based on my medical training and experience, and based upon my research of lethal injection procedures and practices, inadequacies in these areas elevate the risk that the lethal injection procedure will cause the condemned to suffer excruciating pain during the execution process.

23. The information provided includes no exhaustive "equipment list", and is thereby lacking in any assurance that the necessary equipment and supplies are present to ensure that the placement of the intravenous catheter can be performed without needless suffering.

24. The information I have about Ohio's lethal injection procedure provides no specifications regarding the set-up of the intravenous bag of fluids, the drip chamber, the flow regulator, the intravenous tubing, the stopcocks or injection ports or means of injection. It is my opinion based on a reasonable degree of medical certainty, and based on my review of lethal execution procedures in states that have disclosed more detailed information than what I have seen about Ohio's procedures, that there exist many risks associated with whether the necessary equipment has been set up and utilized correctly by people properly trained in the use of the equipment necessary to properly administer any intravenous drugs, including those designed to cause death.

25. The information available to me about Ohio's lethal injection execution protocol contains no reference to plans for dealing with the foreseeable circumstance wherein intravenous access cannot be obtained in the arm or leg. In this setting, state lethal injection protocols typically specify the use of a "cut-down" procedure to access a vein adequate for the reliable infusion of the lethal drugs. Based on my medical training and experience, and based on my research into lethal injection procedures and practices, it is my opinion to a reasonable degree of medical certainty that any reliable, humane lethal injection procedure must account for the foreseeable circumstance of a condemned inmate having physical characteristics that prevent intravenous access from being obtained by a needle piercing the skin and entering a superficial vein suitable for the reliable delivery of drugs. No equipment or supplies for performing a cut-down procedure are listed in the Ohio lethal injection protocol, nor is there information regarding the training, experience, expertise, credentials, certification, or proficiency of the personnel who would perform the "cut down" procedure.

26. Based on my research into methods of lethal injection used by various states and the federal government, and based on my training and experience as a medical doctor specializing in anesthesiology, it is my opinion based on a reasonable degree of medical certainty that, given the apparent absence of a central role for a properly trained medical or veterinary professional in Ohio's execution procedure, it can and should be presumed that the lethal injection procedure Ohio employees creates

medically unacceptable risks of infliction excruciating pain and suffering on inmates during the lethal injection procedure.

FURTHER AFFIANT SAYETH NAUGHT.

I declare under penalty of perjury that everything I have said in the above document captioned AFFIDAVIT OF MARK J. S. HEATH, M.D., BOARD CERTIFIED ANESTHESIOLOGIST is true to the best of my knowledge.

Mark J. S. Heath, M.D., AFFIANT

Sworn to and subscribed before me on this 30th day of December, 2003.

LIA PASCALE
Notary Public - State of New York
No. 02PA6095971
Qualified in New York County
My Commission Expires July 21, 2007

Curriculum Vitae

1) Date of preparation: October 6, 2003

2) Name: Mark J. S. Heath

Birth date: [redacted]
Birthplace: New York, NY
Citizenship: United States, United Kingdom

3) Academic Training:

Harvard University	B.A., Biology, 1983
University of North Carolina, Chapel Hill	M.D., 1987
Medical License	New York: 177101-1

4) Traineeship:

1987 – 1988 Internship, Internal Medicine, George Washington University Hospital, Washington, DC.

1988 – 1991 Residency, Anesthesiology, Columbia College of Physicians and Surgeons, New York, NY

1991 – 1993 Fellowship, Anesthesiology, Columbia College of Physicians and Surgeons, New York, NY

5) Board Qualification:

Diplomate, American Board of Anesthesiology, October 1991.

6) Military Service: None

7) Professional Organizations:

American Society of Anesthesiologists
International Anesthesia Research Society
Society of Cardiovascular Anesthesiology

8) Academic Appointments:

1993 – 2002	Assistant Professor of Anesthesiology, Columbia University, New York, NY
2002 - present	Assistant Professor of Clinical Anesthesiology, Columbia University, New York, NY

9) Hospital/Clinical Appointments:

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1993 – present Assistant Attending Anesthesiologist, Presbyterian Hospital, New York, NY.

10) Honors:

Magna cum laude, Harvard University
Alpha Omega Alpha, University of North Carolina at Chapel Hill
First Prize, New York State Society of Anesthesiologists Resident Presentations, 1991

11) Fellowship and Grant Support:

Foundation for Anesthesia Education and Research, Research Starter Grant Award, Principal Investigator, funding 7/92 - 7/93, $15,000.

Foundation for Anesthesia Education and Research Young Investigator Award, Principal Investigator, funding 7/93 - 7/96, $70,000.

NIH KO8 "Inducible knockout of the NK1 receptor"
Principal Investigator, KO8 funding 12/98 - 11/02,
$431,947 over three years
(no-cost extension to continue through 11/30/2002)

NIH RO1 "Tachykinin regulation of anxiety and stress responses"
Principal Investigator, funding 9/1/2002 – 8/30/2007
$1,287,000 over 5 years

12) Departmental and University Committees:

Research Allocation Panel (1996 – 2001)
Institutional Review Board (Alternate Boards 1-2, full member Board 3) (2003 - present)

13) Teaching:

Lecturer and clinical teacher: Anesthesiology Residency Program, Columbia University and Presbyterian Hospital, New York, NY

Advanced Cardiac Life Support Training

Invited Lecturer:

NK1 receptor functions in pain and neural development, Cornell University December 1994

Anxiety, stress, and the NK1 receptor, University of Chicago, Department of Anesthesia and Critical Care, July 2000

Anesthetic Considerations of LVAD Implantation, University of Chicago, Department of Anesthesia and Critical Care, July 2000

NK1 receptor function in stress and anxiety, St. John's University Department of Medicinal Chemistry, March 2002

Making a brave mouse (and making a mouse brave), Mt.Sinai School of Medicine, May 2002

Anesthetic considerations of LVAD implantation. Recurrent lecture at Columbia University LVAD implantation course.

14) Grant Review Committees: None

15) Publications:

Original peer reviewed articles

* Santarelli, L., Gobbi, G., Debs, P.C., Sibille, E. L., Blier, P., Hen, R., **Heath, M.J.S.** (2001). Genetic and pharmacological disruption of neurokinin 1 receptor function decreases anxiety-related behaviors and increases serotonergic function. **Proc. Nat. Acad. Sci.**, 98(4), 1912 – 1917.

* King, T.E. [δ], **Heath M. J. S**[δ]., Debs, P, Davis, MB, Hen, R, Barr, G. (2000). The development of nociceptive responses in neurokinin-1 receptor knockout mice. Neuroreport.;11(3), 587-91 δ authors contributed equally to this work

* **Heath, M. J. S.**, Lints, T., Lee, C. J., Dodd, J. (1995). Functional expression of the tachykinin NK_1 receptor by floor plate cells in the embryonic rat spinal cord and brainstem. **Journal of Physiology** 486.1, 139 -148.

* **Heath, M. J. S.**, Womack M. D., MacDermott, A. B. (1994). Subsance P elevates intracellular calcium in both neurons and glial cells from the dorsal horn of the spinal cord. **Journal of Neurophysiology** 72(3), 1192 - 1197.

McGehee, D. S., **Heath, M. J. S.**, Gelber, S., DeVay, P., Role, L.W. (1995) Nicotine enhancement of fast excitatory synaptic transmission in the CNS by presynaptic receptors. **Science** 269, 1692 - 1696.

Morales D, Madigan J, Cullinane S, Chen J, **Heath, M. J. S.**, Oz M, Oliver JA, Landry DW. (1999). Reversal by vasopressin of intractable hypotension in the late phase of hemorrhagic shock. Circulation. Jul 20;100(3):226-9.

LoTurco, J. J., Owens, D. F., **Heath, M. J. S.**, Davis, M. B. E., Krigstein, A. R. (1995). GABA and glutamate depolarize cortical progenitor cells and inhibit DNA synthesis. **Neuron** 15, 1287 - 1298.

Kyrozis A., Goldstein P. A., **Heath, M. J. S.**, MacDermott, A. B. (1995). Calcium entry through a subpopulation of AMPA receptors desensitized neighboring NMDA receptors in rat dorsal horn neurons. **Journal of Physiology** 485.2, 373 - 381.

McGehee, D.S., Aldersberg, M. , Liu, K.-P., Hsuing, S., **Heath, M.J.S.** , Tamir, H. (1997). Mechanism of extracellular Ca^{2+}-receptor stimulated hormone release from sheep thyroid parafolicular cells. **Journal of Physiology**: 502,1, 31 - 44.

Kao, J., Houck, K., Fan, Y., Haehnel, I., Ligutti, S. K., Kayton, M. L., Grikscheit, T., Chabot, J., Nowygrod, R., Greenberg, S., Kuang, W.J., Leung, D. W., Hayward, J. R., Kisiel, W., **Heath, M. J. S.**, Brett, J., Stern, D. (1994). Characterization of a novel tumor-derived cytokine. **Journal of Biological Chemistry** 269, 25106 - 25119.

Dodd, J., Jahr, C.E., Hamilton, P.N., **Heath, M.J.S.**, Matthew, W.D., Jessell, T.M. (1983). Cytochemical and physiological properties of sensory and dorsal horn neurons that transmit cutaneous sensation. **Cold Spring Harbor Symposia of Quantitative Biology** 48, 685 -695.

Pinsky, D.J., Naka, Y., Liao, H., Oz, M. O., Wagner, D. D., Mayadas, T. N., Johnson, R. C., Hynes, R. O., **Heath, M.J.S.**, Lawson, C.A., Stern, D.M. Hypoxia-induced exocytosis of endothelial cell Weibel-Palade bodies. **Journal of Clinical Investigation** 97(2), 493 - 500.

Case reports none

Review, chapters, editorials

* **Heath, M. J. S.**, Dickstein, M. L. (2000). Perioperative management of the left ventricular assist device recipient. Prog Cardiovasc Dis.;43(1):47-54.

* Dickstein, M.L., Mets B, **Heath M.J.S.** (2000). Anesthetic considerations during left ventricular assist device implantation. Cardiac Assist Devices pp 63 – 74.

* **Heath, M. J. S.** and Hen, R. (1995). Genetic insights into serotonin function. **Current Biology** 5.9, 997 -999.

* **Heath, M.J.S.**, Mathews D. (1990). Care of the Organ Donor. **Anesthesiology Report** 3, 344-348.

* **Heath, M. J. S.**, Basic physiology and pharmacology of the central synapse. (1998) **Anesthesiology Clinics of North America** 15(3), 473 - 485.

Abstracts

Heath, M.J.S., Davis, M., Santarelli L., Hen H. (2002). Gene targeting of the NK1 receptor blocks stress-evoked induction of c-Fos in the murine locus coeruleus. IARS American-Japan Congress A-15.

Heath, M.J.S., Davis, M., Santarelli L., Hen H. (2002). Gene targeting of the NK1 receptor blocks stress-evoked induction of c-Fos in the murine locus coeruleus. Anesthesiology 95:A-811.

Heath, M.J.S., Davis, M., Santarelli L., Hen H. (2002). Expression of Substance P and NK1 Receptor in the Murine Locus Coeruleus and Dorsal Raphe Nucleus. Anesthesia and Analgesia 93; S-212

Heath, M.J.S., Davis, M., Santarelli L., Hen H. (2002). Expression of Substance P and NK1 Receptor in the Murine Locus Coeruleus and Dorsal Raphe Nucleus. Anesthesia and Analgesia 93; S-212.

Heath, M.J.S., Santarelli L, Hen H. (2001) The NK1 receptor is necessary for the stress-evoked expression of c-Fos in the paraventricular nucleus of the hypothalamus. Anesthesia and Analgesia 92; S233.

Heath, M.J.S., Santarelli L, Debs P, Hen H. (2000). Reduced anxiety and stress responses in mice lacking the NK1 receptor. Anesthesiology 93: 3A A-755.

Heath, M.J.S., King, T., Debs, P.C., Davis M., Hen R., Barr G. (2000). NK1 receptor gene disruption alters the development of nociception. Anesthesia and Analgesia; 90; S315.

Heath, M.J.S., Lee, J.H., Debs, P.C., Davis, M. (1997). Delineation of spinal cord glial subpopulations expressing the NK1 receptor. Anesthesiology; 87; 3A; A639.

Heath, M.J.S., MacDermott A.B. (1992). Substance P elevates intracellular calcium in dorsal horn cells with neuronal and glial properties. Society for Neuroscience Abstracts; 18; 123.1.

Heath, M.J.S., Lee C.J., Dodd J. (1994). Ontogeny of NK1 receptor-like immunoreactivity in the rat spinal cord. Society for Neuroscience Abstracts; 20; 115.16.

Heath, M.J.S., Berman M.F. (1991) Isoflurane modulation of calcium channel currents in spinal cord dorsal horn neurons. Anesthesiology 75; 3A; A1037.

Ohio Department of Rehabilitation and Correction

SOUTHERN OHIO CORRECTIONAL FACILITY
P.O Box 45699
Lucasville, Ohio 45699-0001

Bob Taft, Governor www.drc.state.oh.us Reginald A. Wilkinson, Director

April 19, 2002

Dear

I am in receipt of your request for information regarding the Scott and Byrd executions. I would like to apologize for the delay in responding to your inquiry. While reviewing files, I discovered your request, which I thought I had previously delegated to be completed. This was my error.

I have enclosed a copy of DRC Policy 001-09, Executions, and I will provide you with information the Department has deemed to be public information. The Department considers the record and names/roles of persons participating in the execution confidential based on security considerations, as well as the need to protect the safety of the persons involved in the process.

The gurney/bed and the restraints are manufactured by O.P.I., Ohio Penal Industries.

The intravenous equipment was purchased from a commercial source and consisted of:

01). Angiocath Abbocath-T
02). Primary IV Set No. 1820 (70 inch)
03). 0.9% Sodium Chloride, 1000 ml

The generic names of the pharmaceuticals used are:

01). Pancuronium Bromide
02). Potassium Chloride
03). Thiopental Sodium

There is no cardiac monitoring equipment used other than a stethoscope.

Once again, I apologize for the delay in responding. If you have further questions, please contact me.

Sincerely,

SOUTHERN OHIO CORRECTIONAL FACILITY

James S. Haviland
Warden

TCM/hn

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I trust this information will be helpful.

Very Truly Yours,

Vincent Lagana
Staff Counsel

Copies: Assistant Director
Warden, SOCF
Chief Counsel